Mental Health Medication Advisory Committee Meeting
Meeting Minutes, Open Session
December 9, 2015 at 2 pm – 4 pm

MHMAC Meeting Minutes Open Session HP Enterprise Services Capital Room 6700 SW Topeka Blvd Bldg. 283 J Topeka, KS 66619 December 9, 2015	**Members Present:** Vishal Adma, MD, MS, CMQ, CPE Holly Cobb, NP Brad Grinage, MD Taylor Porter, MD Charles Millhuff, DO Rebecca Klingler, MD Karen Moeller, PharmD, BCPP Nicole Ellermeier, PharmD Aaron Dunkel, Deputy Secretary of KDHE/ Appointed Temporary MHMAC Chair **MCO Representatives Present:** John Esslinger, MD, MMM – United Healthcare Jennifer Murff, RPh – United Healthcare Sosunmolu Shoyinka, MD - Sunflower Jonalan Smith - Sunflower William Mack, MD - Amerigroup Lisa Todd, RPh, BBA - Amerigroup **KDHE Staff Present:** Kelley Melton, PharmD, KDHE/DHCF Liane Larson, PharmD, MPH,KDHE/DHCF Carol Arace, KDHE/DHCF Monica Cuba, KDHE/DHCF **HP Staff Present:** Karen Kluczykowski, R.Ph. Nancy Perry, RN	**Representatives:** Roy Lindfield; Sunovion Colin Thomasset; ACMHCK Kyle Kessler; ACMHCK Katherine Friedebach; Sunflower Amy Campbell; KS Mental Health Coalition Eric Harkness; Citizen Susan Zalenski; Johnson & Johnson Andrew Marzo, KHI

	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order A. Introductions B. Announcements	**Call to Order:** Dep. Sec. Dunkel called the meeting to order at 2:03pm: Well, we will go ahead and get started. For those of you who do not know me, my name is Aaron Dunkel. I am the Deputy Secretary at KDHE and the Secretary is out at a conference this week with State Public Health Officers. So I am going to be sitting in and chairing the meeting, so . . . hopefully we can get through our agenda and have a good conversation. **Introductions:** Dep. Sec. Dunkel: On introductions, have we just been going around the room? Dr. Larson: We did the first time, but we didn't last time. Dep. Sec. Dunkel: Ok. Anybody feel the need to go around the room and introduce everybody? (No audible response.) Ok. I will leave it to the body on that one. **Announcements:** Dep. Sec. Dunkel: Any Announcements? Dr. Larson: Just a reminder on the parking announcement that we normally do that if you're parked past the end of HP there is a possibility you will be towed. Dr. Klingler: Oh, they told us to go past the light pole. Dr. Larson: Ok, umm, so we may want to take a little recess to maybe allow for that . . . Dep. Sec. Dunkel: All right. So, we'll take a five minute recess for people to move their vehicles. Dep. Sec. Dunkel: All right. After the great parking lot great re-configuration, we're all good to go. Another announcement? Dr. Larson: Ok. So the only other announcement I have is that on some of the committee members, I included the financial disclosure form just so that. . .if you could please get that back to me today just that way it will have everybody's notes. Dep. Sec. Dunkel: All right. Any announcements for any of the committee members? {No response.}	

II. Old Business A. Review and Approval of 9/1/15 Meeting Minutes	Dep. Sec. Dunkel: Next we will move on to Old Business. Review and approval of the September 1st meeting minutes. Does anyone have any adjustments to the, or edits to the minutes? All right. Said and done. Anyone like to move for the adoption of the minutes? Dr. Adma: So, I do. Dep. Sec. Dunkel: I have a motion. Second? Ms. Cobb: Second. Dep. Sec. Dunkel: Motion by Dr. Adma and second by Ms. Cobb. Those in favor of. Have we been voting on minutes? I'm sorry I was not here . . . Dr. Larson: We had not yet voted, but … Dep. Sec. Dunkel: Ok. Sorry, playing by my rules. All those in favor of the minutes indicate by saying "Aye." Committee: Aye Dep. Sec. Dunkel: Any opposed same sign. (No one from Committee responded.)	The MHMAC minutes for the September 1, 2015 were approved unanimously.
II. Old Business B. Review and Approval of 10/28/15 Meeting Minutes	Dep. Sec. Dunkel: All right. Thank you. And, now we will move on to the review and approval of the October 28th, 2015, minutes. Anyone with any edits or adjustments to those minutes. (No Response.) All right. Seeing none; would anyone make a motion to accept? Dr. Ellermeier: Motion. Dep. Sec. Dunkel: All right. Motion by Dr. Ellermeier; a second? Dr. Adma: I second. Dep. Sec. Dunkel: Second by Dr. Adma. All those in favor say "Aye." Committee: Aye Dep. Sec. Dunkel: All those opposed? {No one from the Committee responded.}	The MHMAC minutes for the October 28, 2015 were approved unanimously

II. Old Business C. Prior Authorization Criteria	Thank you very much. Get that big part of the stack out of the way. The next piece we had was a review on the Prior Authorization Criteria for the anti-psychotic dosing limits. For the drugs there were some questions with and with that I'll go ahead and turn it over to Liane to give us an explanation. Dr. Larson: Ok. As we discussed last time, there were eight drugs which moved forward with dosing limits and then there were five which were brought back for review and then also in addition we wanted to add on all antipsychotics. So that is what you received in your packets last week was those five that were brought back and then the additional. On here, the sheet that you have in front of you I just put the range since there was some discussion back and forth on those five to bring for committee discussion. Dep. Sec. Dunkel: We didn't have anyone that sent in for comment, did we? Dr. Larson: No. **Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: Ok. Then we'll go ahead and move on to committee discussion. Open floor. Dr. Adma: So let's go ahead and talk about the ranges so at least we can agree on a dosage. So the Abilify dose rate is 30-60 mg parts. Dr. Ellermeier: The initial proposal was 30, but it was asked to be bumped up to 60. Dr. Grinage: I can just reiterate my position, because I think I was the one that kind of pushed that and my understanding is the committee is still looking at outliers and maybe make some recommendations. And, it's just my opinion, you know, community mental health as far as private practice, as far as the "a" patients not necessarily specialty patients. But many times monotherapy is at least as a standard of care, if not I think safer than combination medications. So my recommendations were the ones that I've seen in the community, experience wise, that many people use higher dose that was the Quetiapine, Olanzapine and Aripiprazole dosings and so that is why I recommended up to 60 of Aripiprazole, up to 40 of Olanzapine, and up to 1500 for Quetiapine because that is what I see used routinely by my colleagues. And, so I don't really see that as being an out and that is my position—that is where I am at. Dr. Larson: I do have some data around numbers we pulled from the first quarter if the committee would like to hear them. Dep. Sec. Dunkel: Sure.	Dr. Grinage made the motion to accept with noted amendments. Dr. Porter seconded the motion. The vote was 6 to 1 to accept the criteria with noted amendments made.

	Dr. Larson: So for first quarter of 2015 for all five of these drugs that we are talking about, there were 86 patients above the lower dose. So, for instance, on the Abilify, it would be the 30 mg. Abilify alone it was 43 individuals during that first quarter that was above the 30 mg dose. We did get some breakdown in terms of providing provider type. Thirty-two percent of that was prescribed by non-psychiatric prescribers, and then 68 percent was prescribed by psychiatric prescribers, whether that be at mid-level or Psychiatrist. Just for the Abilify. I have the breakdowns for each of those and then . . . Dr. Adma: Did you look at 45 mgs? Dr. Larson: No. Only over the 30 since we were talking kind of between those two levels. And, then overall between all five of those at the lower doses like I said it was the 86. It was 41 percent prescribed by non-psychiatric prescribers, and the remainder, so 59 percent prescribed by psychiatric prescribers, whether that be mid-level or Psychiatrist. Dr. Adma: That's for the rest of the other medications? Dr. Larson: For all of them and I can give you the breakdown for each of the . . .For the atypicals--for just those five. Dr. Adma: So are you saying that about 40 percent of these prescriptions above the 30 mgs say for Abilify . . . Dr. Larson: Correct. Dr. Adma: Are being prescribed by the primary care physician? Dr. Larson: Correct. Dr. Grinage: Can you name specifically the five? Dr. Larson: So I have the Abilify, Olanzapine, both Quetiapines and Ziprasidone. Dr. Grinage: Oh, two Quetiapines and Ziprasidone? Dr. Larson: Yes. Dr. Grinage: Ok. That is important to know. Dr. Adma: And the difference this would—prior authorization would do is for those 40 percent of the PCPs, they would have to go to a PA process to get an approval?	

	Dr. Larson: As it is now, everyone . . . the way the prior auth is currently written, everyone would have to . . . so those 86 patients they all would be PA'd whether it be . . . Dr. Adma: Psychiatrist, non-Psychiatrist. Dr. Larson: Yes. But I just wanted to give some numbers since there was a discussion about outliers or… Dr. Adma: Sometimes PCPs have found, because they cannot get a Psychiatrist appointment, right? Do you know—do you think that some of this data might be skewed because of that? Dr. Larson: I wouldn't be able to speculate. Dr. Adma: You can't. . . Dr. Larson: It's just by prescriber. Dr. Klingler: This was for at least thirty (30) days though? Dr. Larson: It was for at least. Yes. It was removed if it was less than thirty (30) concurrent days on the dose above that limit. Dr. Adma: Ok. I mean I get your point, Brad. Because you know if you look at the other medications Haldol 60 mgs is what we are saying requires prior authorization which is way above the FDA approved dose, right? For 60 mgs? When I look at Loxapine 250 mg, when was the last time you prescribed more than that? Dr. Grinage: Right. Dr. Adma: So I mean – what I am seeing is I think we need to pick a dose and then start there and then we can certainly you know in future re-look, re-think. We certainly don't want it to be a range. Dr. Grinage: I agree. Dr. Adma: Yes. Dr. Moeller: And, I think we can look at Loxapine, if you think 250 is too high, we can adjust that too. Dr. Adma: Sure.	

Dr. Grinage: I think the issue . . .

Dr. Moeller: I think it is up to us. . .

Dr. Grinage: The issue is I think is kind of like comparing – comparing to the typicals, it doesn't make sense. But that's not really the issue. The issue is prescription practice and safety of the patient. And, in my opinion, and I would say this in a court of law with a reasonable degree of medical. . . Actually with a high degree of medical certainty. Many times it is more advantageous if you have a response at the highest dose, to go over the FDA approved—FDA indicated dose—approved dose that is indicated to go over that given the pathology and it is safer to do that than to add on a second antipsychotic medication. And, I think you know there may be cases where people just won't do that then and then you are going to be having drug, drug interactions in multiple combinations. Think it is a standard of care by most prudent providers, many times, they will go over the FDA recommended dose. Now you can get high, high doses. Then, yes. You may have some concerns. And I think those are the outliers that we should be monitoring. But the reasoning, my reasoning, is it is many times safer and it is still a standard of care that we would be limiting if we kept them at the current doses.

Dr. Esslinger: May I just ask a clarifying question. So, of the three hundred thousand or so members in the three managed care organizations, there is 86 patients that hit this, correct?

Dr. Larson: There were—on these, just specifically those five for first quarter of 2015—there were 86 patients above the lower dosing suggested limits.

Dr. Esslinger: And I would just ask the committee to consider in the interest of safety and quality, is that a huge enough burden since 30 to 40 percent of the prescribers are primary care physicians. So I would ask you to take that into consideration, and once these are prior authorized, they are good for 12 months? Is that correct?

Drs. Larson and Melton: Yes.

Dr. Larson: It is good for twelve (12) months that is correct.

Dr. Moeller: I practice in the in-patient at KU Med and, you know, for the last ten (10) years I mean at times we saw up to 60 of Abilify, but I haven't seen that in probably the last four years or so. Someone—sometimes we see—if it is it may be one person and that is usually someone who will lower it because you know it's not working or something. And, I think you know kind of like what John just said, you know, 86 patients, I'd rather kind of error on safety and getting a prior auth, you know, because sometimes people just keep going and going. And you know some people—primary care—some people don't know the dosing.

	I've seen that even in mental health centers. Some of the, you know, some of the mid-levels—they just keep increasing and increasing and they've never gotten better. So. . . Ms. Cobb: Anything over 60 would need a prior auth is that right? Dr. Moeller: Well, that's what we are debating. Ms. Cobb: Right. But if we move it to 60 then if anything over this it would be? Dr. Melton: 60 or above. Dr. Adma: Maximum FDA approved dose is 30mg, right? So, I mean again, what we're saying is if we say Abilify 30mg is the maximum FDA approved dose and if we stick with that the biggest challenge is in clinical practice; people usually don't practice with maximum FDA, they always tends to go up based on patient by patient. I think what Brad is coming from the point of view saying 'I treat the sickest of the sick' and I really treat from the sickest patient so they need the higher dose. Dr. Grinage: Well not necessarily. No. What I'm saying is that because I see cases all across the state in various settings. If you have a patient at 30mg that has breakthrough symptoms, your options are really the next step, logical step is to add another atypical or typical antipsychotic medication or increase to 45mg. And I would say in many cases, and this is a standard of care, going to 45mg is a better choice than adding another antipsychotic medication. That's what I'm saying. And I think that, based on safety, you're going to hinder some people from wanting to do that, jump through the hoops and get prior authorization. Dr. Smith: There is a third option of determining that agent isn't therapeutically working for the patient and switching to an agent that is working. Dr. Grinage: Well, yeah, but if you have no response, absolutely, but if you have partial breakthrough symptoms where you think you can maximize the response and improve efficacy in a schizophrenic patient that's trying to go to school or a bi-polar patient, then the next logical step; I think we're putting up barriers where they shouldn't be. And that's just; I'm just putting out my opinion there. Now, if you're concerned about non-physician providers we could consider this for Psychiatrists and maybe considering an alternative limitation for non-physician, makes it a little bit more complex, I would consider that. I don't have a good feel for the non-physician providers and the locations. The concern is we have primary care providers in twenty counties out in western Kansas that are trying to provide for mental health patients, that's a little difficult. I can understand a concern for a non-specialty provider or a primary care provider prescribing over those higher doses. Those patients may feel that those patients need special, you know a Psychiatrist; we could certainly address that, but limiting a Psychiatrist to 30mg of Abilify is like limiting your Psychiatrist to 150mg of Sertraline.	

Dr. Ellermeier: I appreciate what you're saying, but I don't think we're saying that they are only limited to 30mg. Once it's above that, there's some thought put in to it. That it's appropriate and that the prescriber has thought about all the things you've just said that this is the best next step for this patient.

Dr. Grinage: My answer to that would be that the prescriber should have been thinking about all of that at a 2.5 mg dose. And so, I guess what I'm saying is that the prior authorizations, I mean, it's a, they do affect, I think they do affect patients, it's like giving a black box warning for antidepressants affects prescription practices. I think we are sending a particular message. That's where I'm at.

Dr. Moeller: I was just concerned; I think that the 3rd option that Jonalan mentioned, was changing maybe there's talk about the efficacy, and that the phone call for the prior authorization that the primary care person may get was has he gotten any efficacy at Abilify 30, and if he says no, then they might say, maybe it's time to change, because, or if you're not getting efficacy at 30 it's about time to give up on that.

Dr. Grinage: If I get no efficacy at 30, most providers would not use that. If you get no efficacy, I think most providers would not go over the FDA approved recommendations unless it was indicated. And the only time it would be indicated is if you have some efficacy sometime between the last dose and the highest dose. If you have some improvement but yet you still have breakthrough symptoms, that's you increase the dose. I think that's pretty obvious that providers go over the recommended FDA dose when it's indicated. And the indication is that the medication is working when you have breakthrough symptoms. So.

Dr. Adma: Taylor, your thoughts?

Dr. Porter: I think I'm just restating things I've said at the other meetings, that a prior authorization process involving a phone call, phone tag, is a behavioral intervention to get somebody to not do something. You make physicians not do that thing that will make them call, find, catch somebody on the phone. So, it's a powerful tool and it shades prescribing practices. There's that. And I think in that way when you opt to keep a dosing low, which I'm at 30, which is just at the very top of the FDA approval, then what you're encouraging then, and the patient is a partial responder, which is almost always the case in Schizophrenia, you are encouraging polypharmacy; which is something we are also keeping an eye on. So I think that we want to be thoughtful about that. Now the more painful PA process for a physician, the more of a behavioral intervention it is, if you simply want the people who are going above the max, to explain themselves, then that should be in their charting and wouldn't necessarily have to be a phone call. That gets to the process of prior authorization in that case. And the other part, in the balance is of what's been stated, this is only 86 patients. So, I agree with that side of the argument, that we're spending a lot of time on something that really would not involve that many phone calls. That's a valid point as well. Those are my thoughts on the matter.

Dr. Adma: From the MCOs standpoint is it possible to make it a 2 tier system of PCP and a Specialist?

Dr. Esslinger: Possible, perhaps.

Dr. Adma: Has it ever been done before?

Dr. Smith: Yeah, we can do it. The challenge I think would be we want to be consistent with this entire policy for all the drugs. So if we just outlined certain drugs, like for Abilify for above…, so then it's inconsistent between drugs within the same policy. That would be the challenge from an operational standpoint.

Dr. Ellermeier: Do we know of the utilization of Abilify in general for that same time frame? Because we're talking about 43 patients above 30. What was the total utilization for the first quarter for Abilify, do we know?

Dr. Larson: I don't have exact numbers on that with me at the moment. I think it would be about 4,000.

Dr. Ellermeier: So 43 out of 4,000 that is a pretty…

Dr. Smith: I can give you our numbers; we had 15,000 Abilify patients for the first quarter and 15 above 30mg. I'm sorry, I mean 1,500, sorry, I added a zero, so 1%.

Dr. Grinage: So, I'm just curious about the typicals you have over the FDA recommendations on the typicals, do we have that?

Dr. Larson: I do not have that information.

Dr. Grinage: I'm just curious because I don't know how much typicals are prescribed in the State.

Dr. Esslinger: I know an essential concern is the prior auth process, and I would encourage us to not abandon the thought and the thinking around it to make it as streamline as possible. To remove as much of the hassle factor as we can. First and foremost we ought to think about safety and quality. Given that 30 to 40 percent of prescribing is done not by a Psychiatrist but by Primaries. We've got 84, that's roughly 7 a month and I suspect any of you that are Psychiatrist aren't seeing 50 percent of the MCO population; it's going to be 60 percent of 84 patients distributed among you. It's going to be a very small number.

Dr. Millhuff: Hi. I'm Chip Millhuff. I wasn't here at the last meeting. What frightens me is the person that's really way off the charts in prescribing. And they're doing things that are dangerous. Such as, not Dr. Grinage here, of course, but someone that is not monitoring for safety measures like vital signs and labs and

	so forth. So I'm wondering about this; one of the things that keeps coming up is how many of our Primary Care Providers are prescribing these. Rather than, if part of the issue is a lack of knowledge, Dr. Grinage, as you've spoken, and others are very experienced at prescribing at these levels, but if someone is out there like in western Kansas, like he said, why don't, if we've talked about in this process, I wasn't here last time, the idea of rather than a prior authorization process, more of a case review for someone who, let's say isn't a child Psychiatrist, but a Primary Care Doctor, so that's an opportunity to teach them how. What is a proper dosing frame for this med. Particularly if you are a Primary Care Doctor that's inherited this case; we're just kind of continuing what's already been there. Therefore that provider then learns how to better prescribe these medicines. Is there, I haven't heard yet, is there any sort of a case review sort of approach that our committee is looking at rather than strictly a prior authorization? Dr. Grinage: Can I just add on to that? I think that was briefly mentioned at the last time. What you're talking about is a pro-active, allowing prescribers to prescribe then looking at the outlier's and getting feedback rather than putting up barriers. Dr. Millhuff: Exactly. Dr. Grinage: I think that approach with providers goes a long way because and it lasts because you are educating the provider. And you don't have repetitive; once you educate the provider they're better prescribers. I don't know if there is a provider… Dr. Larson: We did have some discussion around that. Perhaps the MCOs might be able to speak better about their specifics on it. I do know that they have done it currently. Identifying outliers and sending information. I do know that as part of our DUR program, we've had it before where an individual has gone out, one-on-one, and we haven't always seen results specifically within mental health. There really wasn't any; we didn't notice any change when we tried to do educational outreach. Dr. Klingler: Liane, did we last time, put on a caveat that non psychiatric providers could prescribe but only in cooperation and collaboration? Dr. Larson: Not on this specific policy. Dr. Klingler: Ok. Dr. Larson: That was on the other ones in terms of looking at the monitoring. Along with antipsychotics that's when we put in the language. Dr. Klingler: That caveat, I mean, that kind of caveat's over this dosing limit, doesn't it? Because we've already put that stipulation in saying to prescribe these without prior authorization, you have to be in	

collaboration.

Dr. Larson: That was just the 3 or more antipsychotics.

Dr. Klingler: So that wouldn't apply to single agent?

Dr. Larson: Correct.

Dr. Klingler: Ok.

Dr. Moeller: Does this apply to any age? So could the 12 year old get Abilify 60mg then with no question?

Dr. Larson: Correct.

Dr. Melton: That is something we struggled with because there are some states that have different limits. They have lower limits. Not everywhere, but for pediatrics and then higher for adults. We wanted to try and work with the group to gain consensus globally.

Dr. Millhuff: I talked to Dr. Robert Hilt in Oregon who is in charge of their partnership access line; excuse me, for Washington state. And he explained that, in fact he presented at the academy down in San Antonio just last month that their antipsychotic prescribing practices dropped 25% with this method rather than a prior authorization kind of an approach. And so, I'm wondering as we sort of form or formulate how we're going to get at the issue of safety and good practice whether not we are maybe missing some opportunities that are being utilized by other states that are generating good response. Texas, Colorado, I've heard a great presentation on Colorado's program. That their bringing forward data that's showing that rather than a PA process, they're getting a response where the prescribing practices, particularly since I'm a child psychiatrist, antipsychotics for kids in foster care. Just reintroducing that and maybe I've missed some things here from the last meetings.

Dr. Adma: Dr. Esslinger, now that the MCOs have managed this population for a couple years, they've got some experience under your belt, and you've got medical directors managing this population, then if you look at the numbers, as pointed, it's not a big number comparatively. When you look at the total number of people you're managing apart from the mailers and others as Chip pointed out, have you reached out, have the medical directors reached out to these PCPs and/or Psychiatrists, had a discussion and can you give us feedback as to did that make any difference?

Dr. Esslinger: I think it's a great idea in the long run. I think, as we spoke a little bit about last meeting, we would like nothing better than to reduce our PA requirements. It's expensive for us. It's time commitment for us as well as for you as providers. But we haven't seen much change, I don't think, since it's inspection on

	January of '13 in terms of the prescribing patterns. I don't know, Dr. Millhuff, the details of the studies that you sight, but was it in a closed environment, so to speak? Where they have employed physicians, where they can get absolute cooperation? Would be one of my questions. So, for example, if a person decided not to participate in whatever education we offered or did participate but chose to not abide by the recommendations, what do we have for that? Dr. Millhuff: If you go to the website in Washington you can see a very nice overview of it. What they did is, is in those reviews, the reviewer could set the limits and say this is not acceptable dosing. But it was an opportunity to kind of sort through and understand where the clinician was coming from rather than a hard stop. And, of course, to um, a chance, to um, to also the accessibility of these psychiatrists to immediately provide consultation is a key element. So like if Dr. Klingler is there with a client and you've got a situation, it's like, I can, in these systems they can call and get an immediate consultation with a psychiatrist. I don't think we have something like that going on. Dr. Shoyinka: Let me speak to that. I've actually visited Dr. Hills' program 2 years ago in the spring. It's a pretty elaborate operation and it's been in existence about 10 years at this point. It's taken some time for them to build up to that level of expertise, they, additionally; it's actually funded by the state legislature. I think it's a brilliant idea. You know, they have a whole team and whole staff. Some of their psychiatrists are actually hired out of; they are part time, out of the university, department of psychiatry; so it's a pretty elaborate operation. We've done a little bit of that, in house. We have created a consult line, that's so far not getting used very much, but we both sit down. So we didn't come to this as a first step. We actually went through PMUR process which I think has been well described. But specifically focused on this issue; educating providers, reaching out one-by-one. And what I would say is we saw a little bit of improvement to the individual providers but overall on a system level it's not a very efficient way to do it. Particularly since we are just one MCO and there's a couple others in the State. To your question about what I've seen, in terms of working with individual providers; well, specific examples, I've talked to PCPs, most often in the South East and Western parts of the State around medication issues. I've seen children on Zyprexa 20mg; I saw a 5 year old; reviewed a case of a 5 or 6 year old on 20 of Zyprexa. The PCP had never considered testing of any sort; never considered stimulants, no behavioral therapy, of course it's not readily accessible in that part of the state. That's part of the problem. I think our position is that, you know, this is not an end in itself, we certainly see this as necessary at this point, and it's just one step. This doesn't preclude all the other approaches that have been mentioned. So Chip, I agree with you, if we could have a program like the access line, I'm all for it. Dr. Grinage: Can I clarify? Are the doses the same for child…I mean, we are talking about adults here, right? Dr. Larson: This would be for everyone, as of now. Dr. Grinage: Because, yeah I see that's a lot.	

Dr. Larson: We could defiantly bring back something. If that was what the committee wanted specific to children under certain ages.

Dr. Grinage: I don't have any expertise in that but that's…

Dr. Millhuff: I will say that Florida and Texas all have very clearly defined dosing limits for children. These are already in place; it's not like we have to come up with this from scratch. I don't know why we aren't examining these more directly in these meetings. I mean, I say that respectfully because um, almost seems like we are just trying to come up with where should we set the line, but what does everyone else do?

Dr. Porter: We did look at surrounding states. Instead of what you did, but they did look at something.

Dr. Millhuff: Was that on the dosing amounts? That have been approved for each state?

Dr. Larson: Yes.

Dr. Millhuff: Ok, I'm sorry.

Dr. Larson: When, and again, not being in the psychiatric field and being a general pharmacist; that's really the first place I go. In terms of; and these were just the best suggestions that I have for bringing to the group. To have the experts then look at them and adjust them one way or another. It's really the first place I look at, is all surrounding states. As many as I can look at. And I can bring that up.

Dr. Adma: As she's doing that, Jon, last time, earlier when I asked the question about PCP versus Specialists, now the question is children – adults? Is that easy to set up in the system or is it cumbersome?

Dr. Smith: No, age is real easy. Age is an easy field. If you want to go that way, it's easy.

Dr. Porter: Chip, would you recommend that it be children and adults? The cut-off at 17, or do you think we should put the 14 and over in with the adults' dosage. I guess you suggest what they did in other states.

Dr. Millhuff: It looks like 18 and younger is kind of where it cuts. Younger than 18.

Dr. Porter: The Abilify thing, did we resolve that or are we still on it?

Dr. Larson: No. Still on it.

Dr. Porter: Here, I'll make this as a suggestion or maybe even a motion; I think that having base step above

	the PDR recommended max in the case of partially respondent patient is a good thing to have on all the agents. I don't think it needs to necessarily to be twice the PDR max. So I would suggest a compromise position on the Aripiprazole of 45mg being accepted without prior authorization. Again, that would be my motion regarding that one single medication. Dr. Grinage: So then you have to go through with less work on Ziprasidone and Quetiapine and Olanzapine. Dr. Porter: And basically for at least a 50% increase available without PDR. And that would capture, that'll screen that. Very few of that number we would put at 87, would put at 60mg dose, most of them would have been 45 probably. Dr. Shoyinka: So Olanzapine would be at 45mg then? Dr. Porter: Yes. Olanzapine could be 40, as far as I'm... I think a dose increase is the main thing I want about the PDR. Olanzapine is kind of an odd cat because it's PDR of 20. But even in the KD trial used 30. Dr. Shoyinka: 30, yeah. Dr. Porter: So I think 45, along the lines you've mentioned, probably. Dr. Grinage: Are you suggesting that for the typicals as well? Dr. Porter: I think so. I really hadn't looked at it line by line. Dr. Adma: That makes sense. At least we are following a process. Right? For all these things. Dr. Shoyinka: And I'll just add one thought, just one thought from a clinical standpoint, some of these agents that are partially associated with cardiac conduction block. Would it be reasonable to consider requesting or requiring evidence of that in EKG? Dr. Porter: The only one that would really: Ziprasidone. Or certainly if somebody is giving Mellaril. I think the standard of care; actually, I've got a standard of care expert on the panel; so I'll leave that to Brad. I don't think an EKG is generally required. And with Ziprasidone at least the QTC changes were not dose related. Dr. Shoyinka: How about Haldol? Dr. Porter: Uh, yeah. Dr. Grinage: The only two would be mellaril and droperidol	

Dr. Moeller: Above the maximum are you talking about?

Dr. Porter: The phenomenon is not dose related.

Dr. Moeller: My knowledge is that it was dose related and plateaued out around 200mg. That's my knowledge of Ziprasidone.

Dr. Grinage: When you look at the; and this is pretty detailed; when you look at the scatter gram you get the biggest QTC prolongation of lower QTCs like 430; above 500 you don't... I mean you actually get QTC reduction for Ziprasidone now. And that's kind of the one that's commonly used. Mellaril does have, I think, a black box around it because of its cardiac conduction.

Dr. Adma: The other thing I noticed is that Risperdal is not on this list.

Dr. Ellermeier: We already talked about it last time.

Dr. Larson: That was already approved.

Dr. Adma: Ok. That's what I needed.

Dep. Sec. Dunkel: And so far, moving forward with the list, it sounds like there are two pieces. One maybe going back and readjusting the maximum daily doses. Not only for the five that we were bringing back today, but all of them, based on the conversations that happened a minute ago. And then the other piece is rather do we want to go ahead and have a child's column; a children's' column and an adults column. With different doses, so that maybe we can consider those altogether.

Dr. Millhuff: I think that makes sense, at least that's what I've seen other states. The other thing that I didn't see in the notes from last meeting was I'm a little concerned on the other end of the spectrum, the children younger than 6, the starting amounts. Because that's what really spooked me, with some prescribing practices starting way too high and rapidly going through different trials. That is dangerous to these little guys, and I think we need to have; I know that you guys have already voted on this parameter for younger kids, but since we are talking about dosing, I think if we are going to think about, start with a certain antipsychotic medicine, second generation, I think we should consider some limits as to the highest dose that can be started in a child younger than 6.

Dr. Ellermeier: So we put three limits: younger than 6, younger than 18 or 6 to 18 then over 18?

Dr. Adma: And one more thing to add to your list is sometimes you have the 16 year old who weigh 200lbs.

	So what are the other states doing where these kids as heavy as adults? Dr. Moeller: How do you define children? Is what I was curious about? 6 and younger, because, you have 15 and under… Dr. Adma: So what are the other states doing as they evaluate, because they aren't trying to… Dr. Larson: I did pull up the list here. And this is just for adults, at the other states that I was able to get information from just while collecting it. Um, this does not include children, when I did look at the child limits that varies greatly by state, by the breakdown specifically within age. Some do under 6 limits plus 7 to 13, 13 to 18, some just have limits under 18. It varies greatly in terms of how far they've gone in defining how small of categories of children, and adolescents. So even that varies greatly. But I'm open to bring back anything specific that the group would want to see. Dr. Adma: So… Dr. Larson: …that the group would want to see. Dr. Adma: So, Chip, in a sense I'm hearing 4 categories, less than 6, 7 to 13, and then 14 to 18, and then about 18. Your thoughts? Dr. Millhuff: I would say, yeah, less than 6, let's see, my main thing is less than 6, and then maybe that elementary school age, um, greater than 6 and less than 13; did you say? Dr. Adma: 12. Dr. Larson: 6 to 12. Dr. Adma: 6 to 12. Dr. Millhuff: 6 to 12, that's fine. Dr. Adma: And then 13 to 17. Dr. Millhuff: Yeah. Dr. Smith: One thing I would just recommend is since we don't have any limits on anything at all, and that would be multiple layers and defiantly would hit potentially a lot more PAs, it may be appropriate just like you describe, but, just putting these on for everyone is a pretty big step forward and we can always come	

	back with those other categories, because I'm just envisioning all those adolescents that are large, you know, and or really hard to treat that do hit adult dosing at 16 and 15 years old even, that would create some PA volume. Dr. Ellermeier: So you're thinking like a step-wise approach? Like we'd start with adult limits those would go across the boards, setting the highest dose allowed. Dr. Smith: Right. Dr. Ellermeier: That makes sense. Step-wise it in. Dr. Smith: We're also not turning on; it's not a shock to the system. I mean at this point we'd only be hitting 86, you know, people. Whereas, as you're kind of outlining, that could be really good policy, but it could be a lot more PAs. Dep. Sec. Dunkel: Why don't we go back and we can pull the data by age group. Dr. Larson: I would have to get it from the MCOs. Dep. Sec. Dunkel: Yeah, so, then we'll come back then to you guys and we'll pull it by age group. And we'll go ahead and put together a sheet that has all of it. In kind of suggested levels. Then we can decide if we want to drop off the kids and talk about adults next time around, then we can have that. We'll vote on and kind of split the question, and vote on the pieces that we're comfortable with. Then if it is that we need more conversation around the other 6 or a number. Then we can bring that back for consideration the next time. And one of the things that I would probably say, and want to throw out there just real quick, we still have a good part of the agenda, and I can stay till 5, I'm not sure about you all. But what I wanted, one of the things that keeps coming up in these conversations, is that piece about the primary care physicians. Realistically, after listening to the conversation a little bit, it might be one of those situations where we do have kind of a fabricated PA. Where it's 30 and 30 is ok for everybody, 60's ok for Psychiatrists, if it's between 30 and 60 maybe for a PCP there is a call in. Or maybe what it is, is kind of going back to that post audit kind of mentality, the name of it doesn't come in on a psychiatrists NPI, it shows up between 30 and 60, we talk to the MCOs about doing the post audit on them and then doing a TA, some kind of technical assistance with them, or doing a verification of appropriateness of prescribing practices or whatever we want to do. We can work with you guys, work with the MCOs, kind of talk about how that might be administrative possible. What might be the best approach to it? Dr. Grinage: You've got to understand, my position is coming from just a standard of care for a prudent practitioner. And, you know, 60mg of Abilify for a psychiatrist is not a problem, but when you take a look at a primary care doctor, I don't know if that's their standard of care. And so I think that's very, I think that's…	

[voice trails off]

Dr. Millhuff: Can I just add something to that? I was talking to an Amerigroup doc. A Janet Dreyzehner, I'm not sure I'm saying that right. She's in Tennessee. She said one of the ways that they address the primary care issue is they have a course that they can take and it helps them go over these parameters and prescribing practices and they are utilizing this in Tennessee and when they do that, they become one of these providers that then doesn't have to go through some of these things. That's already in place down in Tennessee. Just one more idea. I can spell her name too: D-R-E-Y-Z-E-H-N-E-R M.D., Behavioral Health Medical Director.

Dr. Mack: Yes, she's one of the Medical Directors with Amerigroup. Tennessee has a different system than Kansas, but yes, they have the program in Tennessee.

Dr. Adma: Hey Jonalan, are you saying, if we go through say these five ranges today are you saying that we can come back and talk about the children's categories at a later time?

Dep. Sec. Dunkel: I think what will end up doing is we'd have this as a policy and then we'd create another policy. Because what really happens, I mean, from an operational aspect, once these are approved they go on the list for the Drug Utilization Review Board. And we don't bring them back for reconsideration until they've gone through the DUR. So we could do that. And then what we would end up doing is having another policy that would be dose limits for children under 18, or whatever we want to call it.

Dr. Shoyinka: Could I add something to my earlier comments? As a practitioner I understand where you're coming from. I practice in Missouri and Missouri has both those approaches. Missouri has a Behavioral Pharmacy Management Program. Which I think you knew about, and that's been in place for about 13 years now. I actually ran that program for a couple years. But in addition to that, you know, there is evidence of improvement, of some impact. That's a state level program. But in addition to that Missouri has certain dos, quantity edits, on around certain, some prescribing, some medication, Opioids, certainly on a child, with regards to prescribing to children. So, that's just kind of coming back to the point I made earlier. I think you have a very good point. I'm not sure if it's going to be enough in it by itself. So that's where my thoughts are coming from.

Dep. Sec. Dunkel: As Chair then I'll ask real quick what the rule of the body is. Do we want to go ahead and try to finalize the adults or the dose that's on the table today and move those forward or do we want to go back and reconsider an adjusted multi-tier.

Dr. Millhuff: I went through this as I was on a committee that did this with Kansas Health Solutions several years back. And what I found is that as we worked through this we were coming up with kind of what the committee felt was a good model and we used that with each class. Some little… My thought is, I'm wondering if we kind of keep these, some of these tabled. You know, I don't know if this makes sense. But,

	because it seems like we're coming up with a method of how to do what we're doing. Like, for instance, these age groups, we've kind of refined that again, and that could serve us well as we go through the next set of medications. And so we've already voted on the previous one, yet we are changing our methods, I'm wondering if we should hold off on making our final decision on what we have. Dr. Adma: Any thoughts? I agree. Makes sense. Dr. Grinage: I guess I just want to clarify of kind of where we're at. For the adult medications for these, Ty had a proposal, I don't necessarily agree with, but they can be compromised, are we going to come back with a specific recommendations on each typicals and atypicals? So we're going to do a little bit more discussion. I think maybe if we have a here's where we're at with the typicals and here's where we're at with atypicals, we'll be able to do some email discussion where I can kind of express my concerns of tying psychiatrists hands. We can also maybe work up the non-psychiatrist provider issue. And then, yeah, it sounds to be like it does needs more time and more input. Dr. Millhuff: You know, and I've reviewed some of the things on this younger group. I mean, some of the diagnoses are not even consistent with our current nomenclature with the DSM. So it's sort of like we're talking about this book, take it home and read it and see how it's edited, and think about it and come back and say hey just a couple more ideas. Because it's a lot to metabolize here, I think. Dr. Porter: One comment here to give the committee a reminder. We have had some opportunity to have some email discussion that maybe we haven't taken as much advantage of as we could have to make this meet, you know, that maybe would have made this meeting move little better. Some of the thoughts would have come up. You know, the recommendations had come to use several weeks ago asking for our feedback. So we can maybe do better, all of us, at getting some feedback out even before the meetings on some of these things. Dr. Ellermeier: Yeah, you know, this is the third meeting we've talked about these limits, I think. Dr. Larson: I've sent them out numerous times in between each meeting. Dr. Smith: I would, I would just ask if you you're leaning towards potentially tabling this to pass at least the higher limits on all these. So that we can at least get something. You can always edit these later. But, at least, if, I mean, if it's 60mg on Abilify, which I think is too high, but, or nothing, it would be great to have something. At least to start. Dr. Grinage: If I could just reiterate what I said last time, I mean, the only ones that I have, like, that I've seen used enough to say, you know, hey, this is pretty, this is used relatively common in patients that actually need it when it's indicated, is the Abilify, the five that I listed, the Abilify, the Olanzapine, Seroquel, and	

	Ziprasidone. I can't speak to the others, the newer like Lurasidone is new enough that we don't know over FDA recommendations; those haven't been tried in state hospital settings and what not. So, I'm comfortable with those five limits. That's kind of what I put forth last time. And I would vote to move on that if it was put to the committee at this point. But I do understand some other concerns and I'm willing to come back and talk about it. That is kind of my discussion that I would have and have had consistently these past three times. Those are the limitations that I have concerns on, those five drugs. Dr. Moeller: That's my one concern we had. And I just want to make sure; Chip said something about a hard stop. These are not hard stops. And so if it is 30 they are going to get a phone call and they can look and say, hey we're going to approve it for a year. So I want to make sure you understand it's not a hard stop. But we have talked about this three times. We've pulled up that table three times. We've picked the upper limits, you know the 30mg from all the states. 30, um, she picked the highest, I think she said from 10 states? 6 states? So she's picked the highest limits. So, I mean, it isn't that harmful to get a phone call. Because there could be some concern. I mean, I just worry about safety. And it's not that they're not going to get the medication. 86 people. And if you do the math, like you've said, that would be maybe one person in your practice, you know, per year. So I think is it really? So, I'm still for the lower dosages on the range. So. Dr. Adma: So here's my thinking; Number 1, if we were to today approve the dose then come up with a plan. This goes to DU board. Dr. Larson: Drug Utilization Review board. Dr. Adma: Drug Utilization Review board, and they approve it. Then that becomes plan, right? Dr. Larson: If they were to approve it. Dr. Adma: If they were to approve it, ok. And then you're saying we can bring it back to this committee, which means basically it would be back on the agenda, where we sit and talk about the children's and all those then. Then they will be another policy change and then that would be going back to the Drug Utilization Review board. So I'm just thinking is that not complicated? Dr. Larson: We're pretty used to that actually with the DUR. For instance with Hepatitis C, we've had it on the agenda every single time. So, I don't; the way that meeting runs pretty smoothly. So just from a logistics standpoint, I don't see an issue with them approving. If you were to do this list, approving, and then coming up with a list for children to add on, just logistically for that meeting, I don't see it being an issue at all. Dr. Melton: And we try to schedule these meetings so there is a good flow of feedback. So for example you guys are meeting today; DUR is the second week in January, the next meeting of this is scheduled for second week in February. So that, you know, if they do have comments on your proposal, you guys would be able to	

	revisit those relatively quickly. Dep. Sec. Dunkel: So I think from an agenda standpoint, you know, it's, what you just said, it's either we do something to approve this today, we come to an agreement, and we move it on to DUR. And then next time we have is just the children's component, and maybe some of these components around post audit about kid limits and things; the PCPs. Or we table it, and it comes back next time with all of it included. But either way the children's piece probably ends up at the DUR; probably ends up on the same agenda; probably at the DUR at the same time. It's just a matter of if you want to do this today or not. Dr. Adma: Ok. Dr. Moeller: As it is now, someone could prescribe 80mg of Abilify and nothing. So, I think that's why; kind of trying. And it's just been three times saying the same. Dr. Ellermeier: Yeah, and you know, I think it's important for us to remember like, we're setting these, but it still has an approval process after us that it has to get through. And then they have to have time to implement these. So, even if we set these today, DUR approves it in January, I don't know what the timeline for implementation is, but it's still months away before these get in place. So the longer we table this and re-discuss it at every meeting the longer providers are able to do anything without any accountability for it. Dr. Adma: With that in mind can we talk about the five categories and come to a consensus as to what we think should be the maximum daily dose then? Deb. Sec. Dunkel: That would be great. Let's do that. Dr. Adma: Let's talk about Abilify last. Let's go with, uh, Seroquel XR® and that's 1200-1500. Anybody with hard feelings particularly… Dr. Larson: I'm pulling the limits up here. These are the other states limits on Seroquel XR®. Dr. Adma: Other states. Dr. Moeller: 1200 is already 400 above the maximum dose. So I mean for allowing some leniency, and yeah I've seen some 1500. But let's give it a call. Dr. Grinage: I guess what I would say is that, again I'm going back to the vision and the objective of this particular committee, is to look at individual providers, outliers, and how to reign those in. This is a standard of care of state regulation. I don't believe it's a standard of care for individual provider prescribing practices. I mean it's helpful to know what other states are doing but I just; would throw that out there.	

	Dr. Adma: So the maximum that other states have had was 1200? Dr. Larson: 800 or 1200. Dr. Shoyinka: I think 1200 is pretty generous, actually. Dr. Porter: Do we know, do we have some numbers on the Abilify? I know this is a non-issue, but do we know how many folks are above 1200 on Seroquel or Seroquel XR®? Dr. Larson: On; Yes; So, on the Quetiapine, for first quarter 2015, there were 9 above dose 1200 limit. Dr. Porter: 1200? Dr. Larson: 1200 limit, there were 9 above that. Ms. Cobb: Is the 800mg limit on there? Dr. Larson: No, sorry, I only did the 1200. Dr. Adma: So 9 out of 300,000 prescriptions? Dr. Larson: Out 340, 000 beneficiaries, there were 9 above 1200. Dr. Porter: It makes it hard to think we need 1500. Dr. Adma: And then for the Zyprexa® what were the numbers? Dr. Larson: Zyprexa®, also 9. Dr. Porter: Above 30? Dr. Adma: Above 30? Dr. Larson: Sorry, not, I was looking at Ziprasidone, sorry. On; there were 43 above on Abilify; 31 above on the Olanzapine; 9 above on the Quetiapine; and 9 above on the Ziprasidone. Dr. Porter: So when you gave 86, that was all of them?	

	Dr. Larson: That was all of them combined. Dr. Adma: So on the Zyprexa®, did you do 30 or 40 above? Dr. Larson: I did the 30. Dr. Adma: Above 30? Dr. Larson: Above 30, there were 31. Dr. Adma: Ok. So we have 4, which is the 5th? Geodon®? Dr. Larson: Yes, 9 over 240. Dr. Grinage: Do you have the percentage of prescriptions? Dr. Larson: Yes, for Abilify it was 1%, Olanzapine - 2.6%, Quetiapine - .28%, Ziprasidone - .9%. Dr. Porter: so 1%, and given the nature of what we are talking about… Dr. Adma: K, so the easiest I'm seeing here is Seroquel and Seroquel XR®, 1200 versus 1500. Um, again, I'm just going to say what I'm thinking is 1200 is reasonable. But, You know I would like to hear from others too. Dr. Porter: And these numbers say only 9 people are indicated above that. I've had a patient above that but not a Medicaid patient. Dr. Ellermeier: And I think only having 9 that shows you that, you know, those are potentially outliers. Dr. Grinage: It's one percent of patients, I get where you can use the flip side of the conversation and say it's only 9 so, you know, why not. That's kind of where I'm coming from. Dr. Adma: And do we just kind of deal with them one of a time? And kind of approve what we want? Dr. Larson: I can make updates as we go. Dr. Adma: One at a time maybe? Dep. Sec. Dunkel: Why don't we go ahead and we'll split the question on it. We'll have, so, if you want	

	1200, go ahead and make the motion on it, we'll get second, and we can talk about it and vote on it. Dr. Moeller: So we can deal with Quetiapine. I'll just go ahead. I will motion on Quetiapine and the Quetiapine XR to have the maximum daily limit of 1200mg. Dr. Millhuff: And are we approving this just for adults? Dr. Ellermeier: This would be for everybody. Dep. Sec. Dunkel: Until we come back with the children's' policy. Dr. Moeller: We have nothing. Dr. Porter: We probably want this inclusive of children because we will probably want a lower number for children. Dr. Millhuff: I'm a little uncomfortable with this. It doesn't have a specifier that this is just for adults. Dr. Ellermeier: Well, I think for right now there's no limit for anybody. So kids can get anything. So what we're saying is let's start here and then break it out to kids later. Dr. Millhuff: I'm just making sure, yeah, that I'm not giving approval to use this limit to younger kids by saying this. Dep. Sec. Dunkel: We'll make a commitment so that on the next agenda, we'll make sure we bring in those children's limits, specifically. Dr. Porter: That's probably another reason to look at some of the lower numbers, because of what you've said, at this particular moment in history, we haven't made children's numbers so this keeps the overall number a little bit lower. Dr. Adma: And the minutes will reflect that, so. Dr. Millhuff: I just want that to be in the record. Dep. Sec. Dunkel: So we've had a motion from Karen. Do we have a second? Dr. Adma: Holly.	

	Dep. Sec. Dunkel: Holly (Cobb) seconded. Ok. Do we have any other discussion on the 1200mg, with specifically on the Seroquel and the Seroquel XR®? Seeing none, all those in favor say 'Aye'. Committee: Aye Dep. Sec. Dunkel: All those opposed say 'Nay'. Dr. Grinage: Nay Dep. Sec. Dunkel: With the majority, we'll go ahead and say that motion was approved. Dr. Adma: Let's approach next Zyprexa®, Olanzapine, 30 versus 40, right? And then I heard 45 also. Dr. Porter: Let's keep it simplified. Keep it at 40. Dr. Adma: Keep it 40? Ok. So, I agree. So, any other discussion? Dep. Sec. Dunkel: Go ahead and get a motion? Dr. Porter: I move that we accept the higher number on Zyprexa. It's more commonly prescribed at that dose. Dep. Sec. Dunkel: Do we have a second? Dr. Grinage: Second. Dep. Sec. Dunkel: Second. Any additional comments, conversation about that? Seeing none, all those in favor say 'Aye'. Committee: Aye Dep. Sec. Dunkel: All those opposed - same sign. Dr. Moeller: No Dep. Sec. Dunkel: With majority, we'll consider it passed. Dr. Adma: Geodon® next. 240 versus 320. Dr. Ellermeier: 240, There are only 9 above 240. So I think it's reasonable.	

	Dr. Adma: Ok. So 240 it is. Do you want to make a motion? Dr. Ellermeier: I make the motion for 240. Dep. Sec. Dunkel: Nicole makes the motion. Second? {The chair recognizes} Holly. {Ms. Cobb seconds the motion} Is there any additional conversation? Seeing none, all those in favor say 'Aye'. Committee: Aye Dep. Sec. Dunkel: All those opposed – same sign. Dr. Porter & Dr. Grinage: Aye Dep. Sec. Dunkel: I'm starting to think maybe hand up. Dr. Ellermeier: Probably do. Dep. Sec. Dunkel: Probably do. All those in favor, please raise your hand. {counts raised hands} 6. All those opposed. {counts raised hands} 2. 6 to 2. Motion carries. Dr. Adma: K. The last one is Abilify. Dr. Porter: That's the one I'd like to make the motion of the higher limit to be 45 in lieu of 30. That's two separate votes, I know, maybe there's 3 things. I know Brad wants 60. Dr. Grinage: It's hard. I mean, just put forth a motion and we'll vote. Dr. Porter: I put forth the motion that the higher limit be 45 on this next vote. Dep. Sec. Dunkel: Second? Dr. Adma: I second that. Dep. Sec. Dunkel: Seconded. Any additional? All in favor raise your hand. {Counts}. All those opposed. On a vote of 8 to nothing, that motion carries.	

	Dr. Adma: So it looks like we got that accomplished. Dr. Moeller: Should we make a motion on all the other, on all the remaining agents? Dep. Sec. Dunkel: Were they on the agenda last time? Dr. Larson: Not on these 8. Dep. Sec. Dunkel: So let's go ahead and have a motion to accept the document as a whole then with those adjustments; with those amendments made. Dr. Grinage: I have to go on the record as saying that um, I think it's an inconsistent process, you know, and maybe we'll want to take a look at them to have such an excessive amount of doses of the typicals but yet the atypicals are, you know, are limited in a sense of having to use a prior authorization. That's all I'm saying. It seems pretty inconsistent to me. But, you know, I'm ok with accepting the documents as is. I just want to go on the record saying that. Dr. Millhuff: Can I say something? Dep. Sec. Dunkel: Yes. Dr. Millhuff: So let's say you've got someone above one of these limits we've just described, if then they are prescribed the dose that's outside of this range, just make sure I understand, that'll be stopped, it will not be filled at the pharmacy. It'll be requested for a prior auth, if I have this straight. And so if that Kansan is out of medicine; I've got a prior authorization request in right now, I called on Monday, it's Wednesday afternoon and I still haven't heard back from the MCO. If you've got an adult on a high dose of this and they're going cold turkey off of it, how does this work out? Dep. Sec. Dunkel: I assume. Jonalan, can you address that? Dr. Grinage: It's ok to say 9 patients, but those 9 patients have a particular life, I mean individually. Dr. Larson: And that was brought up for discussion previously, because when it was first proposed to the group it had just with prior authorization will be require a peer-to-peer consult with the health plan psychiatrist and so then it was broaden to include the medical director or pharmacy director for approval to ensure it was timely, in terms of the PA turn around. Dr. Klingler: What's considered timely?	

	Dr. Porter: Comes out of the State hospital, too high of a dose of medicine and he's two days into it, he hasn't got his medicine. Dr. Millhuff: We were notified Friday that it was denied, PA. Weekend goes by; I call first thing Monday morning; here we are Wednesday afternoon and my phone… Dr. Porter: Isn't there a provision, to give 30, a certain supply while the process is underway? Dr. Larson: Not on this particular one, no. Dr. Melton: But in general, globally, for pharmacy we've got a 72 hour emergency supply process. So they can get a 3 day supply. Dr. Ellermeier: Is there a way to build in history? So if a patient is on 60mg of Abilify, they hit this limit, rather than stopping that claim, allowing one time for. Only if they have history. I'm not saying on new starts. Dr. Smith: I think, on this one anyway, and I think maybe Kelley was going to say this, but our goal, I think, we hadn't talked about the specifics on all these, but obviously cutting anyone off of these doses even if that dose is too high; they need a high dose, so you just stopped it. So our intent, I think, was to message all the providers who have people who will hit these, ahead of time, before we ever even turned on any edits, so that they're aware that this is going to happen; here's how to do the PA; let us review it; because it is going from nothing to something. Dr. Porter: I know this ground has been covered, but again the scenario I just mentioned, it's probably going to be one of the more common and problematic ones; that an individual shows up at our mental health centers having left Osawatomie over one of these limits, and a couple disadvantages. I might not know the person enough to provide a good PA. And two, somebody thought they needed this much medicine and they're going to be cold turkey. I think we, at some point, this part would go on the list, but I think we need to look at the process and really not, try to not to have that. That sometimes leads to headline situations. Ms. Cobb: Knowing these concerns, what thoughts do you have for us? Because these concerns get brought up over and over again. There are so many reasonable limits and reasonable stops to put in at a certain point to say oh check in. But it just comes back to the process knowing that some of those situations might face, what could be, what could be helpful. Dr. Esslinger: My thought is that it's a legitimate concern. We can meet together and come up with a uniform process, something along the lines of what Jonalan said. In cases where we can., give you a heads up, so it's not an 'I gotta deal with this today'.	

	Dr. Porter: Is there a way to, because you don't see the prescription till it hits a retail pharmacy, you don't see what happens in a hospital setting? Dr. Esslinger: Correct. Dr. Porter: Is there any influence to fix, to not have that happen in a hospital; have them come up with a different strategy that doesn't trip the alarm while they're in the hospital; is there any way to influence it? Dr. Esslinger: I think it's very much deserving of a separate discussion. What we've been talking about today very much relies on your expertise as expert clinicians. Good policies that I think are very important and understandably relevant issue is how do we handle these situations where someone has been on a medication and there's a potential gap in getting that approved. We have as much concern as you do in making sure there is no drops. Cause if it fails, the patient's up in the ER or hospital and doesn't do well. So, um, let's noodle it around a little bit more. I think we could probably devote a separate meeting to that process specifically. Dr. Adma: So I think one specific thing that has been brought up is State psychiatric hospitals for example. These are really… Dr. Esslinger: That's a big one, right? Dr. Adma: Right, and then they usually are discharge possibly on a higher than, you know, the limit, that might hit the limit. Dr. Esslinger: By the way are you saying short term or longer term? Dr. Adma: It could be either. Dr. Esslinger: Ok. Dr. Adma: So what happens then is, at least, if the, is there is a process where if you know somebody is getting out of the hospital, could be state hospital could be others too, then that would automatically, at least for the first 30 days… Dr. Esslinger: and could route it? Dr. Adma: Approve it for the first 30 days, with the thought, you know, that within that first 30 days, you know, there's some communication with the outpatient provider.	

	Dr. Shoyinka: So as Dr. Esslinger stated, I think we need to have a broader discussion and include the State hospitals in this; in that discussion. We've wanted to have more visibility to what is happening in the state hospitals for a long time. Everybody is on the same page, with regards, we are all in agreement, we don't want somebody coming out of the state hospital not being able to get their meds. I don't know whether30 days is what I would go for, if it's a safety concern, maybe a shorter time limit. But I think we can discuss this in more detail. Dr. Millhuff: Dr. Shoyinka, the other thing is these foster kids, they get moved and suddenly they are somewhere and they are out of medicine and they are on high doses. They've been very unstable. They are hard to place; it's a weekend, and, boom, they are out of medicine. They are weakened. They have a prescription and yet they're cut off immediately with the risk of withdrawal and other kinds of… Dr. Esslinger: We need a high priority process is what you're saying. Especially in those types of scenarios where they are coming out of a… Dr. Shoyinka: But that's already covered by the 72 hour override, right? Dr. Esslinger: What I'm hearing is maybe they're worried that 72 hours not being long enough. Is that what I'm hearing? Dr. Millhuff: I've got one already. It's been 5 days. Dr. Klingler: And I guess that's my question is that we've talked about the physician's obligation with prescribing. The thing that I'm not hearing in this conversation is the MCOs obligation for a timely review of that. And I think that's the other component here, to avoid Dr. Millhuff's situation, is that we need a stipulation that yes this prior authorization process is in place but as physicians we have an expectation of a certain time to have that completed. Dr. Smith: So we, contractually, have a 72 hour turnaround time, from the time it's submitted. But if he doesn't submit it till Monday when it hit the edit on Friday. That clock doesn't start till Monday. Just to have a reviews' chance… Ms. Cobb: So you've got a patient… Dr. Grinage: Is there a process for weekend submission? Dr. Smith: There is if it gets submitted. I mean, it would get reviewed. Dr. Grinage: I mean a process to put it in on the weekend? There's a means to do that?	

Dr. Adma: Somebody submits on Friday?

Dr. Grinage: I'm just asking, because 72 hours is the window.

Dr. Smith: I don't know; But it would be, the clock would still run on the weekend, so they would have to all be done by Monday. Is that right?

Ms. Todd: I don't think it runs on weekends.

Dr. Smith: I don't know, we don't really get many on Fridays. Because they don't get submitted on Fridays.

{Multiple conversations overlapping}

Dr. Smith: But you're right, everybody gets a lot of hospital discharge on Fridays.

Dr. Esslinger: The hospital Doc writes for it, but you see them as an outpatient 3 days later, that's when the prior auth gets initiated, right? So we are already behind the 8 ball in terms of the timing of that, because we don't see your request until three days after the discharge, perhaps.

Dr. Klingler: Or the foster kid that's out of medicine that's in my office at 4 o'clock on a Friday afternoon.

Dr. Millhuff: And you give them the script and they leave and then they find out.

Dr. Klingler: Yeah, and you know, and before we're prescribing, we're calling Dr. Millhuff or Dr. Evangelidis, or someone saying, you know, what do we do with this? But, you know, as a primary care physician that's Friday afternoon at 4 o'clock.

Dr. Grinage: But also, this is a one time, I mean the prior authorization goes for 12 months. When you've got to do a prior auth on a Friday afternoon, I don't know how often though, but still, I mean, I think it's a valid point.

Dr. Klingler: Especially with medications that aren't like Amoxicillin, you can't stop and start them. I mean, you know, there's other ramifications with that.

Dr. Ellermeier: Do you guys specifically call the provider back to tell them, or do you call the pharmacy? Who do you notify that if it's been approved or denied; I guess is my question.

Dr. Smith: The providers receives a fax response.

Ms. Todd: And if we have a fax number for the pharmacy, it does get faxed to the pharmacy. But to your point, kind of where I was going, is that I think that we could do a better job, also, of educating our pharmacies to remind them of the 72 hour override. Because there are times that I think there are a lot of times practicing pharmacist don't even realize that. They just see the rejected claim and they're like, oh, it requires PA, sorry I can't do anything, right? As opposed to maybe we, as MCOs, can really go out and, you know, really educate again the, you know, pharmacists, that for any PA not just for these mental health, this is true for all PAs.

Dr. Grinage: So any PA, if it's initial prescription, you can get 72 hours' worth of medication.

Ms. Todd: Yes, and the, and even if the PA is technically denied or whatever, then the pharmacy is still made whole for that drug, so the pharmacy isn't, you know, if the pharmacy is worried about, you know, getting that claim paid.

Dr. Grinage: I think that's education…

Ms. Todd: Right? So I think it needs to bring out, I mean, it's been around for years, but I think it would be a big advantage for us to go out and promote that again.

Dep. Sec. Dunkel: Last spring we specifically, very purposefully, reiterated that component of the policy, that even if it's denied, they will be made whole. Because that was feedback we are getting from pharmacists. And we said, no, that should not be an issue.

Dr. Adma: Again, we are talking about patient safety.

Dr. Smith: We could to look at longer than 72 hours. I mean, just to see what makes sense. I mean, on this one, makes sense, some of the other ones, you know, the third antipsychotic, probably not, you know.

Dr. Adma: I think for patient safety that would be one area where we would ask you to look at it and say what is reasonable. I think with the weekends included and all that stuff and if you can come up with a number and come back and say this is what we're thinking might makes sense.

Dr. Porter: I was just going to say, that most of the; there's a couple of things we're grappling with here, when we get to the outliers, there's going to be some of them that it's bad medicine and there's going to be some of them, it's good medicine. And it's hard to know from looking at…; but on the ones where it's good medicine, where the person really needs that outlier medication, then they're probably a pretty sick, an individual with a pretty bad illness, so in that way it's kind of a conundrum, that's probably one of the last people you would want to have not get their medicine. I think that's one of the things we're grappling with

here, how to screen the bad medicine out from the good medicine and without hurting a patient in the process. The other thing I would uh, but I was just thinking of that.

Dr. Melton: MCOs do you guys have internal resources related to state hospital discharge that we could maybe better engage? Do you have case managers that work with patients while they're inpatient there, that maybe if we know they are going to be leaving we can maybe better coordinate with their prescribers in the community and this is what we can get set up for them?

Dr. Shoyinka: We have case management, but we have very, very poor penetration into the state hospital system.

Dr. Melton: Ok.

Dr. Shoyinka: They will not talk to us. I've tried to talk to them many times. They won't talk to us. And, in addition to them maybe that's something this committee can look into as well; there is a significant discrepancy between the prescribing practices within the state hospital system and current evidence, current standards. Often, not always, but often.

Dep. Sec. Dunkel: And we're going to be having an additional conversation with you guys over state hospital stuff as part of the contract discussion moving forward.

Dr. Smith: I actually have a quick question on the other drugs. You mentioned, you know, how that the typicals are quite a bit higher on some of these. Which ones would you say are the biggest? I mean, Haldol, which were outliers as far as extreme?

Dr. Grinage: Loxapine.

Dr. Smith: Oh yea, Loxapine.

Dr. Grinage: You're making me go back to medical school.

Dr. Grinage: I don't remember 64 mg for Perphenazine, you know, I would have to look at them, the one that just stand out, is you know, anything over, I mean, you've saturated your D2 receptors at 20mg of Haldol, 30mg, ok I'll give you an extra 10mg, and anything post that is just sedation.

Dr. Smith: I agree.

Dr. Grinage: You know, and but an increased risk of EPS and that sort of thing. But back in the day when that's all you had, you know, we used 60mg in the state hospital. I don't know that they're doing that now,

	although, I think that the problem with state hospitals is that there some physician recruitment issues and so that's probably your prescription practices. Dr. Millhuff: I'll keep this very brief; Dr. Shoyinka, this is part of the reason why I think that the PA method is not sophisticated enough from my vantage point as a front line clinician. I would rather have a review of these sorts of cases, so I think it would be nice if there were a balance more than just the PA. One other comment that I'll just make about these overall guidelines that we are trying to approve here, I just want to ask the committee, as we think about what's been approved for pediatric populations in terms of lab work, is metabolic syndrome any less a concern in adults and why don't we consider that in all this. Sorry to say that, but I'm sort of like why are we making these recommendations for kids, to have this as a preliminary measure, blood work before meds, and then 6 months, 12 months, all these things, yet we're not looking at that in our adult population. Dr. Grinage: That is a standard for adult population. Dr. Millhuff: We highlighted in our pediatric guidelines, why wouldn't we highlight it in our adult populations too? Dr. Shoyinka: We're all for that. Dr. Millhuff: I don't mean to make this more complicated, but. Dr. Porter: I think that's one, again, that I was, that I spoke to when we were talking about the kids, without a full understanding process, because that's one that's been recommended without going through a phone call process. That's one that's been ok'd to send the information to the MCO, chart review, it's not a call of the MCO doctor on that particular one, for the kids. And I think it makes it less onerous. Every time you make a phone call you can't see a patient during that time. But, expanded to the adults, that's going to be a big bunch of fish you're bringing in there. Adherence rates to those recommendations, among adult populations are poor. Dr. Shoyinka: Poor, very poor. Particularly the waist circumference. Dr. Porter: We can make it better with what we're talking about here, but you're going to have a lot of stuff to sort through when you start trying to deal with that particular issue. Especially when you're trying to meet all the ADA guidelines, the waist circumference, etcetera, really spend some time on that for adults I think. Dep. Sec. Dunkel: Excellent conversation. What's the rule of the committee on the amended Antipsychotic dosing limits policy?	

	Dr. Grinage: Accept as we noted. Dr. Ellermeier: The 30 for Haldol? Dep. Sec. Dunkel: It is 60 based on the conversation we had last time. Dr. Shoyinka: No opposition to cutting Haldol back. We're good with that. Dr. Grinage: You know I, yeah, you know, what I would want to do, and again, I'm approaching this from outliers, and standard of care, and I don't have a real feel for the typicals because we've kind of moved on from those. I don't have any particular suggestions. I'm ok with this, as is, because it doesn't put up a hindrance to our psychiatrists. But if there are some real safety concerns then we probably need to look into that. I don't have any data on. Dr. Melton: I don't think that we were. I think the idea was just that if we were going to cap the atypicals we didn't want the typicals wide open because we didn't want to push utilization there. Dr. Smith: And the challenge Liane had was other states haven't capped typicals where there was other states comparators for atypicals. Dr. Grinage: I still have a problem with us making decisions based on other states. Dr. Smith: I understand, that's just, she went really high because there wasn't a comparator. Dr. Ellermeier: It was a good starting point for recommendations for us. Dr. Larson: It was just anything I could find from other states. Dr. Grinage: I'll move that we accept as is. If that's just another agenda item we want to put on down the road, we certainly can with the typicals. Maybe make some recommendations but for the sake of the agenda, I accept, I would move to accept as is with the amendments to the five drugs we discussed. Dr. Porter: Second. Dep. Sec. Dunkel: Any additional discussion? Seeing none, those in favor raise your had please. Those opposed. Dr. Millhuff voted no and Dr. Adma abstained	

	The vote is 6 to one; the motion is carried. Thank you very much. And we will, just as a note, we will make sure, we'll work with Liane and Kelley over at the agency and have some information on children the next time around, on the next agenda. And we'll try and work through some of that. Because, point well taken, we had a lot of conversation with that internally prior to bringing this out the first time. So I think it won't be that hard to put that information together. Dr. Millhuff: Is my main point of contact Liane for information? Dep. Sec. Dunkel: Yes. She's kind of our lead staff on the committee. Dr. Larson: Some things I have to get approval to release though. Dr. Millhuff: Ok, because I sent questions to you. Dr. Larson: Yes, and I did receive it. Anything I can release at the moment, I'm normally pretty good about trying to get back, but with some of the things, I have to get approval first before I can release out. Dep. Sec. Dunkel: Especially some of the sub cabinet information has to go through the data release request, just like anything else that comes through the agency. We've been trying to fast track that, but every once in a while there gets to be a little discussion with our data folks about whether they; their feelings on how discreet we can be. That closes out old business. Unless anyone else as any additional.	
III. New Business A. Prior Authorization Criteria 1. Use of Multiple Concurrent SNRIs – Review proposed clinical criteria for patients prescribed multiple concurrent antidepressants. a. Prior Authorization Criteria b. Clinical Public Comment * c. Committee Discussion	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: New business. If we can look at the Use of Multiple Concurrent SNRIs. Dr. Porter: I'd like to suggest on that one, that we add an agent even though it's not technically a psychiatric med. I think that Savella should be on this list. Dr. Smith: Dr. Shoyinka just wrote that down. Dr. Moeller: I agree. Dep. Sec. Dunkel: Does anyone have an issue with adding that? If not, we'll just take it by consensus. Dr. Porter: You'd be surprised by how many non-psychiatrists have no idea the mechanism or action of that medicine.	Dr. Adma made the motion to accept as amended. Dr. Grinage seconded the motion. The criteria were approved unanimously.

	Dr. Shoyinka: They prescribe it liberally. Dr. Grinage: The only thing that I might, and I don't know how much I feel about this, but the 30 days, sometimes if you're doing some changes or trying some different things, might upgrade it to 60 days. Didn't we change something to 60 days? Dr. Ellermeier: I think it was like 2 or more antipsychotics. 3 or more antipsychotics? Dr. Grinage: Give them a little bit more time. I don't know how people feel about the trial time period. Dr. Ellermeier: On these are they gonna be really… Dr. Grinage: I usually, if I'm like switching SNRIs and SNRLs, I go more than 30 days. But I don't know how other people feel about the trial time. Dr. Shoyinka: Do you see them just once or do you see them multiple times during that period? Dr. Grinage: It depends on what my schedule is and how stable the patient is. Certainly someone whose risk assessment is moderate to high, I would see them a couple times during the switch process. Sometimes I'll actually even overlay and then decrease rather than do a titration switch. Dr. Shoyinka: Titration switch. Dr. Grinage: Just depends on how/what the patient… Dr. Shoyinka: That's what I do too. Dep. Sec. Dunkel: To give you an idea on volume, because we had an update on this in our meeting the other day, you know, for the two distinct SNRIs antidepressants, the count for unique beneficiaries in the first quarter of 2015, was 63. Dr. Ellermeier: On 2? Dr. Shoyinka: What was the duration? Dr. Larson: over 30 days Dep. Sec. Dunkel: And for the benefit, Dr. Adma can you tell us what the addition was again?	

	Dr. Shoyinka: Savella. Savella. S-A-V-E-L-L-A. Dr. Moeller: Milnacipran. Dr. Grinage: Say again? Dr. Moeller: Oh, just Milnacipran; Savella. Dep. Sec. Dunkel: Ok, it's up there now. Dep. Sec. Dunkel: Outside the addition of the additional compound, is there any additional? Dr. Adma: What are the numbers for this? Dep. Sec. Dunkel: In the first quarter of 2015, we had 63 unique beneficiaries that had 2 distinct SNRIs over a 30 day period or longer. Dr. Grinage: It would be nice to know if that changed to 60 days. Dr. Adma: So what we are talking about then is if somebody prescribes Pristiq and Effexor then we get a PA. Is that what we're talking about? Dr. Adma: I make the motion to approve the criteria for prior authorization as requested. Dep. Sec. Dunkel: We'll do it as amended. Second? Dr. Grinage: Second. Dep. Sec. Dunkel: All those in favor, please say 'Aye'. Committee: Aye Dep. Sec. Dunkel: All those opposed, same sign. {Silence} Dep. Sec. Dunkel: Thank you.	

III. New Business A. Prior Authorization Criteria 2. Use of Multiple Concurrent SSRIs – Review proposed clinical criteria for patients prescribed multiple concurrent antidepressants. a. Prior Authorization Criteria b. Clinical Public Comment * c. Committee Discussion	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: Next we will move on to the Use of Multiple Concurrent SSRIs. I will throw out the numbers. When Liane ran the numbers, we had 273 for the first quarter. Dr. Grinage: How many? Dep. Sec. Dunkel: 273. Any discussion? Dr. Porter: I have to say, this is one of those ones where I think it's kind of hard to justify that many people. It makes it seem that somebody's not being careful, to me. Although in my practice I have somebody, a patient or two on more than one SSRI, because they tell me they need it and it works. It's an unusual thing. Dr. Moeller: I think cross titration would probably be our biggest issue. Somebody may go longer than 30 days on a cross titration. Dr. Adma: Could we change it to 60? Dr. Shoyinka: That's ok, yeah. Dr. Porter: You know, especially for that high of a number, just for the body of work that's going to…, two hundred and seventy something? Dr. Ellermeier: 273. It does seem high. Dr. Adma: Sometimes them not getting an appointment… Dr. Ellermeier: Could be multi prescribers that aren't aware of… Dr. Porter: I think this is one that would probably capture bad/mistaken plans. Dr. Moeller: Because is someone has been on it for, let's say, 5 years at the highest dose and they want to change them over to Sertraline; I could see a slow titration, a 2 months titration possible. Dr. Grinage: I would be consistent with the SNRIs, or else you're going to have to explain to the DUR, er, Drug Utilization Board. Dr. Moeller: Yeah, you're right.	Dr. Porter made the motion to accept as amended. Dr. Adma seconded the motion. The criteria were approved unanimously.

	Dr. Smith: I don't know, I think the SSRIs dose can get pushed higher than the SNRIs. I don't know, I feel like the titration could be slower, don't you think? Dr. Grinage: I don't mind 30 or 60. I don't think I have anybody on 2 in the same class. I can see cases where that might be. Dr. Esslinger: My only comment would be, is it worth a phone call to check because your point earlier, two different prescribers, they both think they are initiating the drug and yet they are doubling up on it. Dr. Porter: You know what really happens is you are in your physician's office, you cancel, you switch, but this is mainly a situation in the pharmacy that does a refill on the first agent. And you don't call the pharmacy and tell them to quit delivering the Celexa. I think this is will catch some mistakes. It's probably one of the better ones we've got. Dr. Grinage: There's a lot of people that you'll switch over but they still have active medication on their pharmacy list. But they're not taking it. Because they've stopped. Dr. Adma: My feelings is, that whatever we do, we need to do to be consistent in terms of SSRIs and SSNIs in the terms of timeframe. What that means is we have to probably have to go back and amend to what we've approved just now, for 30 days, right? For the SSRIs? Dr. Esslinger: Are you ok with 30 on both? Dr. Ellermeier: If we allow 30 in there say for one type of medication, so then they would get approved for that second agent. Dr. Moeller: I could go either way. Dr. Shoyinka: 45 days. Dr. Moeller: 45 is my lucky number. Dr. Shoyinka: I do agree with the consistency though. Dr. Porter: Um, I'll put a motion out, but I don't have strong feelings about it, I'll say, I make a motion that we move both classes, including the amendment to the SSNI to 60 as the times it is an appropriate thing that they are on both, there might be some lengthy titration. Doses can be quite high. That will do the job, of the people that are past 60 with a higher percentage of bad medicine than good medicine.	

	Dep. Sec. Dunkel: Second? Dr. Adma: I second. Dep. Sec. Dunkel: Any other or additional comment? {Silence} All in favor of amending both of them to 60 days, approval please say 'Aye'. Committee: Aye Dep. Sec. Dunkel: All opposed, same sign. {Silence} Ok.	
III. New Business A. Prior Authorization Criteria 3. Use of Multiple Concurrent Antidepressants – Review proposed clinical criteria for patients prescribed multiple concurrent antidepressants. a. Prior Authorization Criteria b. Clinical Public Comment * c. Committee Discussion	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: Next we'll move to Use of Multiple Concurrent Antidepressants. Liane, do you want to do the run through? Dr. Larson: So this is basically what we've been talking about, the other antidepressants, except for this is across classes. So the criteria as proposed would allow for 3 or more antidepressants used concurrently for greater than 30 days would require prior authorization. Dr. Moeller: One problem I see with this is that I do see in practice, I do see 3 used, you could have SSRI, you could have Wellbutrin, you know and then you could have Mirtazapine for sleep. I'm a little worried that with Mirtazapine we could hit a lot. I think we could hit a lot. Dr. Larson: For that exact issue we removed Trazadone from the list. Dr. Grinage: And there's more than that for sleepers. Dr. Moeller: A lot of people are using, but you could be using for neuropathic pain, headache, prophylaxis. A lot of people could be using, you could be using duloxetine, its got general skeletal muscle pain indications, so I do have some concerns. Dr. Porter: What numbers do we get on this? Dr. Larson: So on the three distinct antidepressants excluding Trazadone, 224. Four or more including Trazadone -, 48, excluding Trazadone -16.	Ms. Cobb made the motion to accept as amended. Dr. Adma seconded the motion. The criteria were approved unanimously.

	Dr. Adma: So they might be on SSRI, SNRI, and, I guess, Trazadone, that's 3 right? Dr. Porter: It's different than the other one, even though the numbers are similar. Because there's really is no good rational for 2 SSRIs. You know, There might be an individual case. But you can't really make a good argument where as we would have fairly commonly using rocket fuel combinations. Two sometimes three if you include Wellbutrin and a dual acting agent would be a described treatment that's accepted for severe refractory depression. Dr. Moeller: Doxepin has an indication as a hypnotic. Irritable bowels sometimes. I guess the numbers weren't too bad. Dr. Grinage: Just looking at this if I was going to, from policy standpoint, to try and make something practical, it would be minus the tricyclics except for the Clomipramine; minus Doxepin and minus Mirtazapine, and that's because those are readily thrown on board for multiple purposes, not just sleep. Just trying to craft a policy. Dr. Moeller: Just for clarification, take off Doxepin, Amitriptyline, and Mirtazapine. Dr. Grinage: Yeah, Imipramine and Nortriptyline cause those are used many times neurologically for multitude of conditions. Dr. Porter: This is an interesting discussion. The only thing about that would be you've got the last two that you mentioned, the tricyclics, we're not so good with them as we used to be. We don't use them as much. People forget, you know, they are 2D6 metabolized, so if you combine those bad boys with and Prozac at a high enough dose you've just got a pretty toxic situation. Dr. Grinage: There's cardiac risk factors with them too. So you know there's certainly safety issues going on but I think you're going to find a lot of folks on dual combination antidepressant in neurology for headache, or for sleep, or for irritable bowel syndrome, even in kids. You're using it for multiple reasons. Dr. Shoyinka: Do you see a lot of people on two Tricyclics? Dr. Grinage: Say again? Dr. Shoyinka: Two Tricyclics. Dr. Grinage: I do not. I probably would not. I have had neurology's start nortriptyline and imipramine and then instead of adding an SSRI, crank up their imipramine to get rid of their panic attacks. Same way some have used some of the blood pressure medications as psych medications for psychiatric purposes. I think you	

	can easily have one of these criteria for Tricyclics antidepressants and say you have to have prior authorization for two. Because we have that for the SSRIs and the SSNIs, it makes logical sense to me. I don't know if there are people on two Tricyclics. Dr. Adma: What are the numbers for four or more? Dr. Larson: On more than three it's 48. Dr. Adma: Four or more is 48. Dr. Larson: That's including Trazadone. If we exclude Trazadone, because we looked at it both ways, it would be 16. Dr. Adma: What are the other states doing? Is it three or more? Four or more? What are they doing? Dr. Larson: It's a combination again in terms of, a lot of times this is managed as well through their PDL. In terms of what is their preferred agents and step therapy for things and what not. But I did see quite a bit in terms of SSRI, SSNI, and then the three or more warranted a discussion. I don't have a chart on it; I just have some of their individual criteria. Dr. Shoyinka: Those exclusions are reasonable I think. It makes sense to me. Dr. Porter: It takes you a little bit beyond that, what we're trying to accomplish with this, what I brought up before. There's a couple agents that just two together, if people aren't thoughtful about it, is a safety issue. But I think that's too much finesse to try and do what we're doing here. Dr. Adma: So we are talking about taking Amitriptyline, Doxepin, Imipramine, Imipramine Pamoate, out of this list? As well as nortriptyline and mirtazapine out of this list. Dr. Moeller: What are your thoughts on Protriptyline? And then maybe thinking about filing another criteria, you know, two or more Tricyclics. Dr. Ellermeier: A separate policy? Dr. Moeller: A separate policy. Dr. Ellermeier: For more than 60 days. Dr. Grinage: Or you could look at it as the four or more.	

	Dr. Ellermeier: I don't know. The more agents that are added on the more side effects. Is it better to remove some of these drugs or up the limit of the number of therapies that are allowed before a PA? Dr. Adma: Four instead of three; is that what you are thinking? Dr. Ellermeier: Yes. Dr. Shoyinka: I am ok with the latter option. Which would be to remove some of these common… what you said earlier. Rather than leave it at four drugs; I feel uncomfortable with that. Dr. Melton: We can pull data on concurrent Tricyclics and bring that back if you would like us too and potentially look at that from a standalone issue. Dr. Adma: Ok, any other thoughts? Dep. Sec. Dunkel: With the removal of the ones that are highlighted from that list then… Dr. Adma: Change 30 days to 60 days for this also then? Dr. Grinage: Can someone educate me on Trimipramine? Is that a Tricyclic … I assume it is… Dr. Moeller: I assume it is. Dr. Grinage: Is it old or is it new? Dr. Porter: I remember it but I have never prescribed it. Dr. Grinage: I had someone come in the other day on Tranxene. Dr. Shoyinka: it's a Tricyclic. Dr. Shoyinka: I have never personally prescribed it but… Dr. Grinage: I don't know what that is used for… I have not personally seen it used or utilized. Dr. Moeller: I don't know that it was still on the market. Sometimes you will find some drugs that have been removed but they might still be listed but ...	

	Dr. Grinage: Well someone was using them and they had to get a prior auth if they're going to use two of them. Dep. Sec. Dunkel: While they look that up and they give us information on that do we want to… as far as an edit goes do people feel more comfortable with 30 days or are we looking at 60 days as Dr. Adma threw out a second ago? Dr. Ellermeier: I think 60 to be consistent. Dr. Adma: What I don't see on this list is Selegiline. That is another MOI now that we have other MOI's. So add Selegiline to this list then? Are we at a point where we make a motion/discussion? Dep. Sec. Dunkel: Are there any more additions/deletions/edits that folks would suggest? Dr. Smith: Did the Savella get added too? Dr. Moeller: Addition of Savella has been added, has been requested. Ms. Cobb: My thing with duloxetine, Cymbalta is there are a lot of other primary care indications for that. Is that a concern of yours? For Cymbalta, Rebecca? Dr. Klingler: Not really. Dr. Klingler: I would say with kids the one we see the most is would probably amitriptyline and imipramine used for alternative uses mostly in neurology and GI. Dr. Grinage: For explanatory purposes are you wanting pull these out and say these were withdrawn simply because they are used commonly in combination for other conditions? It might be worth just noting that. Dep. Sec. Dunkel: Yes we can definitely note it on the documentation, because of the DUR. Dr. Millhuff: I have seen it on a list where it is an asterisk at the bottom of the list that says this number does not include X, Y and Z drugs. Dep. Sec. Dunkel: with the additions/deletions and the adjustments to 60 days and including a parenthetical notation that the ones taken off were taken off for… due to their wide use in other clinical… however you want to word it I am not a practitioner at all. I'm a finance guy. That is why I can't pronounce hardly anything on here. With that do we have a motion for acceptance?	

	Ms. Cobb: Yes. Dep. Sec. Dunkel: We have a motion from Holly. Do we have a second? Chip? Chip has a comment. Dr. Millhuff: As we get through this does this sort of encompass our discussion as a committee on anti-depressants? Dr. Larson: This is just the beginning. If there is something/anything that you would like me to bring back I have notation to bring back the tricyclics next time. So if there is anything else that the committee would like to focus on or for me to bring information on; the proposed criteria. This was just again looking at other states; what other plans are doing; where we started to start. Dr. Grinage: Do you feel that there needs to be different for childhood/adolescent? Dr. Millhuff: Most definitely, in my mind is completely in child and adolescent world and if this committee is really about safety and good practice we're not giving attention to that with this… if we move on from anti-depressants and we don't talk about this. We are not looking at those kids out there that shouldn't be with these kinds of limits. So I will just make that comment. Dep. Sec. Dunkel: For the next agenda we would be more than willing to either have an e-mail for face-to-face conversation with you about some things we might want to do to bring in as policy for the group to consider because that is one of the reasons we wanted someone who is specifically working with children. Dr. Millhuff: Quite frankly a lot of the other states from what I have been researching it is like a whole separate protocol. Texas, Florida you can look at the adult stuff and you can look at the kids' stuff and… Dr. Esslinger: And it makes sense for a lot of reasons; two-thirds of our memberships are young people. Dep. Sec. Dunkel: And a huge emphasis for this entire group being put together was children and safety so I think that would be very welcome. Dr. Grinage: The other population is the general population. Standards of care can change for the general population as well. Just throwing that out there. Dep. Sec. Dunkel: Again, I think those are things that we… We kind of started with some of those children pieces at the first… second meeting and these were kind of a little more generic and a larger population. I think getting back to having some of the conversation around children or the geriatric group would be exactly where we would like to go. Do we have a motion from Holly?	

	Dr. Adma: I would say go ahead and second it. Dep. Sec. Dunkel: Any additional discussion? All of these in favor say Aye. Committee: Aye Dep. Sec. Dunkel: All of those opposed same sign. {Silence.} Thank you. Dr. Adma: Before we move forward I would like to take make a comment. When you talk about prior authorization process there is a P2P consultation with a psychiatrist, medical director and pharmacy director right? Would the MCO's… are they ok with a PA form being filled-out by a practitioner instead of an actual phone call? Have you thought about… this is ok but also think about times when Friday afternoon you need some documentation from folks on your side but the practitioner they are able to go ahead and fax you; this is the information. Dr. Esslinger: We do that today at United. We welcome that; we encourage that. Dr. Adma: So it's not a phone call all the time? Dr. Murff: Fax, online, or phone. Dr. Smith: I think the reason that got listed on there was it was impossible to come up with criteria that would be consistently approved with three or more whereas like with this next one… that is clear you have met this criteria… that is easy to do on a form with three or more anti-depressants. That is kind of automatically outlier status. I believe that was the intent right? Dr. Melton: Yes. Dr. Smith: Not really a check box at that point. Dr. Larson: Because there was as the committee was speaking before in terms of using more than two anti-psychotics in children or three with adults. You know; there were so many different possibilities that could be legitimate cases for doing that. That is why it was prompted to have more of a discussion between medical professions versus just on a form trying to explain where a provider was coming from in terms of why they felt the medication was an outlier. Dr. Adma: Another question I have is once this committee approved these they are approved by the Drug	

	Utilization Board how are our patients and clinicians notified about these changes? Dr. Melton: I think we're going to get into that a little bit later on the agenda. Because right now, thus far we've had kind of a lengthy process before you can put a drug on PA. But the MCOs are required to do notification to prescribers before they implement a PA on a drug. But specific to the initiatives of this committee, I think we wanted to do a little bit higher level outreach in implementing different policies. That is to say there will definitely be communication, and outreach, and definitely forewarning that these are coming; but we are also open to suggestion if you guys have suggestions to do more effective outreach. 02:10:53 Dep. Sec. Dunkel: In the interest of everybody's time. We're scheduled to 4 it is now 4:05. Is everyone ok with continuing? {Committee members note 4:30 as agreeable} Dep. Sec. Dunkel: 4:30? Ok, so, why don't we go ahead and we'll try to do a hard stop at 4:30 then. And we'll get through the remainder of the agenda by then.	
III. New Business A. Prior Authorization Criteria 4. Use of Benzodiazepines and Buprenorphine Products – Review proposed clinical criteria for medication assisted treatment program patients prescribed benzodiazepines. a. Prior Authorization Criteria b. Clinical Public Comment * c. Committee Discussion	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: So next we'll do Use of Benzodiazepines and Buprenorphine Products. I'll turn that over to you. Dr. Larson: The criteria you have in front of you, that's why I made this one in color, this is just regarding what is written in red. The other criteria is criteria which has currently already been approved and is in place. This has already gone through our DUR Board. This is just looking at the indication of using Benzodiazepines with Opioid dependent agents. Just those two bullets. Dr. Porter: Could anybody else use background on this? I don't prescribe… Dr. Grinage: I do my training this weekend. Dr. Shoyinka: I do. Dr. Larson: The concern is there's been an increase in overdoses linked with using Benzos along with Opioids and Opioid dependents agents. And that's where the concern comes from because of the respiratory depression using both of the drugs. So this is something that I know other states have discussed at conferences between pharmacy Medicaid directors in terms of looking at this as criteria as a safety edit.	The criteria were tabled till next meeting.

Dr. Moeller: What's the percentage?

Dr. Larson: In ours, the first quarter of 2015, we had 229 patients on a Buprenorphine product and 55 of them had been dually prescribed with a Benzo. I tried to do an initial look and it looks to be 50/50 in terms of if that was the same prescriber or a different prescriber. And that's just a preliminary look where about half the time we have it where it's two different prescribers, one prescribing the Benzo and one prescribing the Buprenorphine.

Dr. Porter: Here's another, I guess, uninformed question. You're targeting Morphine or isn't the concern then for all Opioids?

Dr. Grinage: It is. As a matter of fact the VA initiative is moving everyone off of either Benzo or the Opioid narcotic, you can't be on both in the VA system, that's a Federal, or that's a VA initiative.

Dr. Shoyinka: With one little exception Buprenorphine is different in that it has a ceiling effect. What that means is you don't get any more benefit after a certain dose. We talked about saturation of receptors. It's a partial agonist. But it's not safe when used in combination with Benzos.

Dr. Porter: More unsafe than regular?

Dr. Shoyinka: No. It's the same. There's no good reason to that I can think of. First of all you're treating a population that is dealing with addictions, generally.

Dr. Grinage: I think what Ty is asking is why are we addressing Benzo and narcotics?

Dr. Ellermeier: I am going to assume it's because that not all Opioids are PA'd, but all Buprenorphine products are.

Dr. Smith: And maybe not all people taking Opioids have a substance abuse disorder. Where all people taking this drug would have been diagnosed with substance abuse disorder.

Dr. Porter: That's interesting. Because this is not really a psychiatric medicine is it?

Dr. Smith: No, but Benzo is.

Dr. Shoyinka: Well to the extent where you consider addiction a psychiatric disorder.

Dr. Porter: I got ya. Opposed to meds used just for pain. I got ya.

	Dr. Shoyinka: Doesn't work that well in practice, I can tell you that for sure. Dr. Porter: We don't have anyone on the panel. Are you currently doing a Suboxone practice? Dr. Shoyinka: No, I ran my clinic for two years. Dr. Porter: I know you're not officially on the panel, but you sound like the one with the most experience. Dr. Grinage: I'm signed up to do it. This has been an initiative goal ever since the oxy explosion and combination Benzo with narcotics being an issue. I'm not familiar and I don't know what the VA policy has been with the Suboxone, but I assume it's probably similar because of the substance abuse background of patients on Suboxone. Dr. Moeller: I think it's a big concern on all Opioids. Just like you said, you don't know how the VA is doing it. I look at the 30 days, I'm afraid that we're going to cold turkey people. But I don't have a really, but I don't think 60 days is necessarily the best thing either. Dr. Shoyinka: My opinion on that is that is considering the safety risk the other way, Dr. Moeller: That's what I'm saying. Dr. Shoyinka: I would rather err on the side of potentially having to withdraw them. Both medications, concurrently. Dr. Grinage: I'm kind of with Ty. I feel a little bit at this point like I don't have a good enough grasp to cast an intelligent vote. Probably what I would do is go talk to my Suboxone guys at the VA and get a feel for that before I felt comfortable to vote. That's kind of where I'm at. Dr. Adma: I don't have any experience with Suboxone either. So can we table this? Dr. Porter: It's a high percentage. It's about a fourth of the people getting Suboxone that would meet this criteria. And it sounds risky to me too. Just repeating, I have no experience with it. It does seem, if we are worried about safety, if we are worried about overdoses and killing people all over our state, all over our country, I don't know why we would just focus on just this one and not on the combination of other Opioids. Dr. Moeller: I think something people need to look into, an additional thing is having Naloxone ready in case of overdose.	

	Dr. Porter: And they always give that… Dr. Moeller: They're giving it to take home now. Dr. Grinage: Naloxone kits Dr. Moeller: Naloxone kits, saving lives for people. Dr. Porter: Apparently heroin is making its way to middle America. Dr. Shoyinka: We've had an explosion of Hep C and HIV infections, new infections in Indiana. Dep. Sec. Dunkel: Is there anyone on the committee opposed to tabling this till next time? {Silence} Then that's the action we'll take then.	
IV. Process Improvement Initiatives – For informational purposes only A. Preferred Prescriber Status 1. Committee Discussion	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: We've got 17 minutes. I'm not sure how far we can get into a preferred provider status conversation. Um… with preapproval we've kind of had some of that conversation already so I think we can probably avoid that. Say, why don't we uh, we'll start the conversation, uh, spend about 15 minutes real quick, talk about Preferred Prescriber Status just in general. And we've got a lot of feedback from different folks about how this might work. You know, one of the things that continually comes up, and think I haven't seen anybody that was against it yet – and Liane & Kelly, if you did, let me know – was, really that the first criteria would be psychiatrists; that we wouldn't, at least in the initial round, we wouldn't do anything around preferred prescriber status for anyone who wasn't a psychiatrist. Again, that's just the feedback that we've received so far from the folks that have given it to us. That would probably be a good first point, to have a little bit of discussion about being that we are heavily psychiatrists around the table. But does that make sense to everyone? Does anyone have concerns about that? Dr. Adma: What can they do, what can they not do if you are a preferred prescriber? Then what? Dep. Sec. Dunkel: The preferred prescriber status would basically allow (at least in, again a general concept, this is all kind of open for discussion, and it's probably a policy we'll put in place more than something that comes from this committee--we are asking this committee for conversation and thoughts) would be that it would keep them from having – basically they'd have an automatic PA on	

	anything they did. Now, my suggestion back is that that doesn't mean that the MCOs would completely stop doing post-audit against prescribing practice, because you might have somebody that for some reason all of a sudden starts doing things that they shouldn't. And we don't assume that to be a large percentage of folks, but maybe. At least we need to, if it is, we need to at least verify that people are continuing to be good prescribers and they're following prescriber practices. Um, we've had, there's one….kind of the basic breakdown on the grouping then is, when you get to saying, Ok, psychiatrists are the ones who would qualify as, for that, so we wouldn't do it yet for APRNs or PCPs or anybody else, at least in the first year. And then it breaks down…okay, does that mean all psychiatrists get it or do they have to have a certain—there has to be a certain level of comfort, because we know that, even within the psychiatrist community there are some folks that, when we go through and you look at what their prescribing practices are, there are some that are questionable. Dr. Grinage: Are you talking about board certification that's tracking those kind of providers, or…? Dep. Sec. Dunkel: No, and that's where we'll have to sit down and say: Okay, what's our criteria? And really the criteria we set would have to be based on what we see in their interaction with our Medicaid population. Dr. Shoyinka: Should it be specialty-specific? You know, because we have a child psychiatrist in the room, I wouldn't ask for preferred prescriber status in child psychiatry. I might ask for it in other areas. So, that's a question, beyond just specialty, should it be subspecialty-specific? Dr. Ellermeier: I mean maybe the other side of it is, if you're looking at maybe six months of prior authorizations and you have prescribers where a hundred percent of their PAs are being approved and they're psychiatrists, maybe they get preferred status because they are always able to explain themselves and get things approved. Dr. Porter: But that's kind of back to the devil in the details, because when you go through a prior authorization process sometimes, I'll talk to Dr. Shoyinka and it's a very collegial and helpful process, and other times you talk to somebody who just says, "No—doesn't mean the criteria." And so you may… I think, if the prior authorization process is a good one, that makes sense, but that's the question. Dr. Millhuff: My thought is, and I'll get back to what I said before, I like that idea about being	

	exempt from this prior authorization, but I still think review should happen if there are certain signals for it. Um, you know, there was a doc, someone who called me before we kind of got started with the dose authorization. We talked about some of these kids that I had on a lot of medicine. It was very collegial, like you say, Ty, and… but it was appropriate, you know, I'm like, "Ya, he's on a lot of medicine, this is what we're doing…" But I think that I wasn't offended by that; it was a supportive conversation, and I think that keeps—if we did exempt someone like, with board certification, from the prior authorization but still that we're some signals, if they were way out there, you would still check on it. Dr. Porter: Well the problem with that standard of board certification is – it does something, because passing your boards is an accomplishment, it means something, but you know, I'm grandfathered in; I'm never taking another board certification in my life. And some of you…I think I'm still good at my job, and someday I may need the pen taken from my hand, and may not know it, and have board certification and not have two neurons working. So, I think maybe there's something besides board certification that we're gonna want to keep an eye on. Dr. Grinage: So, I think one issue would be figuring out how the provider is established in that particular category, and then, what's maybe a secondary system of review. I would be much less reticent on the dosing levels if I would have known, if we had talked about the provider status initially, because I agree with the proactive, more of: "Hey, let's allow providers to prescribe, and then go back and review it." Maybe some of the dosing schedules that we just established here might be means of where a person is on preferred prescriber status you might look at some of those and if there's questions. They would just due to review, but they don't … that might be a means to do what you were saying to do, but then the question really becomes is: What providers –how did the providers become, get placed in that status? Dr. Adma: Has this been established in other states, and if so, can you talk a little bit about it? Dr. Shoyinka: We have tools that actually analyze individual prescribers as well as practices against certain metrics. We look at the appropriateness of prescribing, you look at the quantity limits, you look at whether the patients in that person's case [have been/are being?] adequately or appropriately monitored, and that is, you know--there's a competence score that's assigned to that individual. And so, you know, this is something that's, um, we've looked at prescribers across the state and … Dr. Adma: It's an evidence-based kind of process when, in the sense that you use some metrics--	

Dr. Shoyinka: Yes.

Dr. Adma: --You use metrics and say, this might be a preferred provider versus others—

Dr. Porter: This is a great way where you actually can help patients by the sort of thing we're talking about, because if you – once again, we don't want to do prior authorizations, and if we know that getting more labs drawn on our atypicals will keep—will get us in a status that makes our life easier, we'll do it, and speaking as a physician, I think that's a really great concept.

Dr. Ellermeier: I think that maybe another thing to consider is, once a provider has been determined to be a preferred prescriber, maybe there, with the retro-review of claims, maybe – you know, the participation and outreach—if a provider is in preferred status, but then you see something retrospectively and they're not willing to participate in any education or any sort of dialogue retrospectively, maybe that's the trigger to get them removed from the list. Not to say that---

Dr. Porter: It will be a badge, not a tattoo then? [Audience laughter.]

Dr. Smith: Ya, one of the things we just kind of wanted to throw out there was, all objective data, right--kind of like you said, metrics--because, otherwise, from a review process, if there's subjectivity, it would just be for us unsustainable. So, we had kind of thrown out, minimum, you know—psychiatrist, a minimum number of our patients, because if you've only got 10, you know is the PA burden, you know 10 total patients, not 10 PAs—10 total patients—you know, so we want to avoid those providers that are high volume with Medicaid, HEDIS measures which are nationally recognized—you know that we're measured on, you can measure prescribers on. If you're in a good percentile on that, which is to the point of the lab draws and things like that, and then maybe like at 90 percent or some sort of threshold for PA approvals, because 100 percent, you know is--we don't expect you to… you know, like you said, it's not going to be every time you maybe gets approved right away if its…

Dr. Grinage: I think it addresses the whole concern about non-specialists too, because you know, then you're going to have closer scrutiny on your primary care provider folks that be able to prescribe.

Dr. Porter: The PA process, the other thing that's, it's an uncomfortable topic, but I don't know if

	all the MCOs are in line with each other or, they're, but if the reviewing person is incentivized on their percentage of denials, it's something that works against just doing something based on safety, and I know that's maybe not something that's for us to know who aren't in the company, but I do think that's uh—that adds a twist to this thing about it being a helpful and a safety-based review when you as a reviewing physician are punished in some way every time you say it's ok. Dr. Smith: I can assure you that's not—there's no financial incentive… I'd have to ask Dr. Friedebach our chief medical officer, but I mean, I think the biggest review comes on if there's a… we monitor the number of approvals but also the number of appeals that get overturned, so if the chief medical director and does an appeal review and the initial denial was inappropriate, you know, we're tracking that. Dr. Friedebach (Sunflower): I know that the MCOs to be accredited with NCQA it's explicitly, you know, decreed essentially we cannot do that; so there's no incentive. And we in fact have to sign a statement saying we are not given any incentive for denial rates. And as Jonalan was saying, denial rates in general say a lot about the company and their processes. For example, if you don't have very many PAs your denial rate may be higher. If you have PAs on things that maybe you shouldn't, your denial rate may be lower. So, in general, our denial rate is something we may look at to make decisions on should we PA this at all? But there's no disincentive for a provider. Dr. Grinage: But the reliability between denials I think is the concern—one of the concerns between that and, you know, I like the idea of using it more or of maybe using this as a proactive education and I don't know whether, you know, to become, again I think providers will be motivated if you, if maybe have an education protocol or something to go through first to be able to get on, or something like that. I think I would echo what Ty has said that there are some concerns about the reliability between reviewers, if you're… but I don't – I can't make any evidence for that. Dr. Millhuff: One thing, as I've been thinking about this is, what Texas does is, instead of deciding that a psychiatrist is a good, they'll say—they kind of go at it from a different angle, and I'll just read from what is for kids. They say, you could be subject for review "if prescribing by primary care provider who has not had documented previous specialty training for the diagnosis other than ADHD, uncomplicated anxiety, or uncomplicated depression." So, it kind of comes at it from the other angle. If you have PCP, and I was mentioning that program to have taken some specific training, then you can develop an exempt status, but otherwise, if you don't have that kind of background, you're subject to this PA process.	

	Dr. Adma: Um, and just to talk about nurse practitioners, there are some experienced nurse practitioners who do incredible jobs. We really want to take into account not just the psychiatrists, but also, you know, psychiatric nurse practitioners who've been in practice for several years or something like that. Ms. Cobb: Absolutely. Dep. Sec. Dunkel: Well then, I'll tell you what we'll do. We'll sit down—we kind of sent out the request to the MCOs and got some feedback, but it was more of a, send us a document type of a process. And what we'll do is we'll sit down with them and have some more conversation about – both from an operational standpoint how we can do it, something that makes sense, taking into consideration some of the comments around education and being able to send things out that way, and bring it back for the next meeting. Hopefully, the next meeting. It might not be February's meeting, it may be the one after that, because we've got a pretty long agenda now based on some of the conversations. But we'll see if we can get something a little more concrete. Dr. Grinage: I think you can say overall, the committee is in favor of this, and I think it's a really great idea. Dep. Sec. Dunkel: I'm glad we had the conversation and that it was kind of loose because it… some of the ideas that came out were things we either had considered and kind of went, well, maybe that's not important, and it's been reiterated, yes—it probably would be important, or it was things we hadn't thrown into the coffer yet, so I appreciate the conversation. Thank you very much. Dr. Adma: A quick question. There has been something that I heard about, about the information discussed on this committee. Is this public information? And, if so, if somebody wants to review what has been discussed, when is it posted someplace so that they could--- Dr. Larson: I post the agendas two week prior to. We have not released any of the meeting minutes or anything like that because they had not been approved by the committee, so I didn't want to release anything that had not been approved, but other than that, we do not release--- Dr. Adma: Minutes are posted, once approved, they minutes are posted someplace?	

	Dr. Larson: I don't believe we have….we don't normally post minutes. Dr. Adma: What do we do? Dep. Sec. Dunkel: They'd be available through a request. Dr. Adma: Through a request… Dep. Sec. Dunkel: If somebody was to get a hold of Liane or get a hold or our core officer--whoever, and request those, we would release those. Dr. Adma: Okay. And then, in terms of public comment what does that mean? Dr. Larson: So, public comments, the way it was set up from the beginning, is that, if… I post the agenda two weeks ahead of time, and then from that point until one week ahead of time from the meeting, any public comment requests that I receive, whether it be clinical public or open public comments, will then be added to the agenda, depending on where people want to/indicate to have their public comment. So for that period of time, it's open for one week. Um to let me know what it is they're wanting. Dep. Sec. Dunkel: We left it on the agendas just to make sure everybody was aware the ability was there, even though we haven't had any. Okay, with that, thank you all very much. Susan Zalenski: Asked about public comment and availability of relevant criteria prior to MHMAC meetings. Dep. Sec. Dunkel: Stated that suggestions were noted and they will be reviewed.	
IV. Process Improvement Initiatives – For informational purposes only B. Pre-Approval Process 1. Committee	**Clinical Public Comment: -** No requests were received. **Board Discussion: -**None	

Discussion		
V. Open Public Comment*	**Public Comment: -** No requests were received. **Board Discussion: -** None	
VI. Adjourn	Dep. Sec. Dunkel: We are adjourned. {4:30pm}	
*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to llarson@kdheks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received.		